Culture and the Stress Process: Understanding Mental Health among African Americans

A DISSERTATION

SUBMITTED TO FACULTY OF THE GRADUATE SCHOOL

OF THE UNIVERSITY OF MINNESOTA

BY

Sirry Alang

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

Donna McAlpine, Advisor

May 2015

ACKNOWLEDGEMENTS

This dissertation would not have been possible without the extraordinary openness of the people in “Upper Lake Heights” who shared their lives and stories with me. They welcomed me into their spaces, educated me about their experiences, challenged my assumptions and intellect, befriended me, and ensured that I was safe. Although my words and work cannot fully articulate their experiences or the lessons I learned, I strive to become a better person and scholar because of them. I was amazed by their strength and resilience in the face of unconceivable challenges. I am very grateful for their willingness to engage with me, and for several tangible and intangible resources that they provided to make this work possible.

I am indebted to my dissertation committee. My advisor, Dr. Donna McAlpine, is one of few people I know who strike a rich balance between being a brilliant academic and an amazing human being. Whether in academic advising, financial assistance for conferences or research mentorship, Donna has been consistent in her support. She cheered me on to discover and follow my own academic trajectory, and made it easier for me to take intellectual risks while trusting in the support and criticism that she offered. Certainly, Donna invested immeasurable professional resources in my training. But all these fade in comparison to who she has been as a person. She listened, believed in my abilities, talked about the things that matter to me, encouraged me, advocated for me, celebrated my successes, and constantly nurtured me to strive for better, and to laugh when things were hard. I would never have made it through doctoral studies without Donna, and I feel fortunate to be mentored by her.

My committee members, Dr. Kathleen Call, Dr. Sarah Gollust, and Dr. Douglas Hartmann have been extremely supportive. I am grateful to Dr. Call whose timely and relevant feedback from when I began thinking about my dissertation to completing this work has been invaluable. Kathleen held high expectations for me from my very first semester in the doctoral program, and has been a constant supporter. I am indebted to Dr. Gollust for motivating me to do quality work, for being attentive to detail, and for challenging me to think about the implications of my work from the beginning. As a scholar and teacher, Sarah provides me with a perfect example for how I want to conduct myself as junior faculty. I am grateful to Dr. Hartmann whose passion for ethnography inspired and motivated me to conduct this work. Without him, this dissertation would have remained an idea.

I received support and advice from faculty outside of my dissertation committee. I am grateful to Dr. Todd Rockwood for helping me with so many personal and professional things to mention. I thank Dr. Rosalie Kane who often made time to provide feedback on my work and ideas. I am grateful to Dr. Enid Logan, Dr. Jeylan Mortimer, and Dr. Cawo Abdi, faculty in the Department of Sociology, for providing support and training. I thank Dr. Michelle van Ryn and Dr. Margarita Alegría who although outside of the University of Minnesota, took an interest in my success, encouraged me, and reminded me of the scholastic and practical relevance of this work.

I am grateful to Maureen Andrew, masters and doctoral health services research program coordinator, for ensuring that I had all I needed and for helping me to navigate complex processes within the division. I am particularly indebted to my person, Ellen McCreedy,

for always being there, and to Dongjuan Xu, Dr. John Amuasi, Andrew Wilcock, and Dr. Schelomo Marmor, friends and colleagues who stood with me during my most difficult experience in the program. I extend thanks to Heidi McLeod, Jules Przedworski, Intan Suwandi, and Dr. Kathleen Rowan for their friendship in the past years, and mostly for listening to me complain about how much work I still have to do. Of course, myriads of friends from the division, in Minnesota, in the U.S., in Cameroon, and in different parts of the world to whom I owe recognition of their contribution to my success are not listed here. I appreciate all of their support.

Every career starts with moments of inspiration. I am grateful for the mentorship I received from Dr. E.Yenshu Vubo, Dr. Fongot Kinni, and Rebecca Eposi Ngeve of the University of Buea, Cameroon – my first intellectual home. I extend special thanks to Lehigh University faculty: Dr. Judith Lasker, Dr. Karen Hicks, and Dr. Bonnie Coyle (also Director of Community Health at St. Luke's Hospital, Bethlehem, PA) for introducing me to the sociology of health, illness and healthcare, and for facilitating my first health services research experiences in the U.S.

I am infinitely grateful to my mother, Margaret M. Tanni, for her love and constant encouragement, and for giving immeasurably to make my life better than hers. I thank my entire family for their support of my academic endeavors. Finally, I am grateful to my wife, Kimberly Anne. As someone outside of academia, she was very understanding of my needs throughout doctoral studies, especially when I was dissertating. Her support and encouragement were, in the end, what made the completion of this dissertation possible.

ABSTRACT

This dissertation explores the role of culture in shaping stress and mental health among African Americans in a disadvantaged urban neighborhood referred to as Upper Lake Heights (ULH). I use ethnographic methods to characterize stressors, identify shared resources and responses to stress, and describe common ways of expressing depression - an outcome of stress. I also employ cultural consensus techniques to quantitatively estimate the degree to which knowledge about stressors, resources, and expressions of depression are common or shared among African Americans living in ULH.

In ULH, salient stressors are constructed through mechanisms of social comparison and expectations around social mobility. Salient sources of stress include racism, gun violence, police harassment and role strain. Although traditional stress resources such as mastery and self-esteem are dominant moderators of the effects of stress on health under the stress process paradigm, the main resources employed to manage stressors in ULH are religion and the family. Culturally salient responses to stress include impression management and John Henryism. In general, mental health problems are described and understood in the context of a person's abilities and roles within their community. Although in some ways consistent with DSM-V categories, depression in ULH is mostly expressed in ways that are neither in the DSM nor operationalized in community surveys.

These findings have several implications. First, the context of stress shapes responses and resources, and whether negative mental health is experienced. This context includes racism and discrediting views about Blacks which are associated with impression

management and John Henryism. Second, depression is expressed in ways distinct from classic DSM symptoms. Administering standardized instruments and obtaining results consistent with DSM disorders does not mean that symptoms acknowledged by African Americans in ULH are the only or most familiar ways of expressing depression. Third, implementing programs and policies that would improve the living conditions of residents including access to structural resources will reduce vulnerability to stress. Addressing structural racism is crucial. Finally, at the level of clinical practice, knowledge about how culture shapes the expression of psychiatric distress will inform the diagnosis and provision of patient-centered mental health care in ULH.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Chapter 1

INTRODUCTION

1.1 Background

There is a substantial body of research documenting that social and economic disadvantage and discrimination, stressful life events and strains, and traumatic experiences are risk factors for physical and mental illnesses. The overwhelming evidence that Blacks in the United States (U.S.) are exposed throughout their lives to more of these risk factors has been used to explain why of all major racial groups, U.S.-born Blacks have the highest rates of mortality and morbidity from physical health problems (Levine et al. 2001; Murray et al. 2006; Williams and Jackson 2005). It is surprising, however, that despite exposure to these risk factors; Blacks have similar or lower rates of common psychiatric disorders compared to Whites (Breslau et al. 2005; Breslau et al. 2006; Kessler et al. 1994; Kessler et al. 1997; Williams et al. 2007). Understanding the underlying mechanisms by which patterns of disparities in mental health become paradoxical to the patterns observed in physical health is one of the major challenges in mental health research.

Thus far, three main hypotheses have been advanced to explain the paradox of lower rates of common mental disorders among Blacks: methodological error, self-regulation and resources. Methodological error is presumed to occur when selection bias leads to underrepresentation of Blacks in population-based mental health epidemiologic surveys (Williams and Earl 2007). One of the main reasons advanced for the measurement error hypothesis is that Black males are disproportionately in jail (Pettit and Western 2004)

where psychiatric symptoms may be more common. As a result, community surveys typically capture healthier Black males. However, a relatively recent study found no support for the selection bias hypothesis as Black females also exhibited better mental health than both White females and White males (Keyes 2009). Another methodological error is measurement bias where the instruments used to assess symptoms in community mental health surveys are not equally valid for Blacks and Whites (Alegría and McGuire 2003; Brown et al. 1999; Kleinman 2004). Breslau et al (2008) investigated whether Blacks were likely to respond differently from Whites to twenty questions that assessed depression in the National Comorbidity Survey (NCS). Differential response patterns were found for three items for which Blacks were less likely to endorse symptoms of depression: lack of energy, feelings of worthlessness, and suicidal thoughts. However, when these items were removed, Blacks still had lower rates of depression, suggesting that race differences in the evaluation of some items of depression did not explain the overall lower depression rates among Blacks (Breslau et al. 2008).

A second hypothesis is that certain self-regulating mechanisms are more common among Blacks and affect their mental health in different ways (Jackson and Knight 2006). Based on this proposition, Blacks under stress are more likely than their White counterparts to engage in unhealthy behaviors such as smoking, drinking, and eating "comfort food". While such unhealthy behaviors affect physical health over time, people who engage in such behaviors are less likely to suffer from depression because they immediately engage in perceived stress-reducing mechanisms (Jackson and Knight 2006; Jackson, Knight, and Rafferty 2010). However, research with nationally representative longitudinal data did not find support for the self-regulation hypothesis. Blacks neither engaged in

unhealthy behaviors more frequently than Whites, nor did these behaviors protect them from depression (Keyes, Barnes, and Bates 2011).

A third hypothesis is that resources such as education and income, social support and relationships, mastery and self-esteem, may vary by race, and have differential effects on mental health. Yet, analyses using data from the NCS and from the National Survey of American Life (NSAL) found that church attendance and support from spouse, kin and friends did not explain why Blacks had lower rates of disorders (Kiecolt, Hughes, and Keith 2008; Mouzon 2013; Mouzon 2014). Although the quantity and quality of social and church-based relationships were better among Blacks than Whites, the presence of these relationships did not explain why Blacks had lower prevalence of major depressive disorders (MDD) and depressive symptoms even though they did worse on socio-economic indicators. Recent analyses of NSAL data exploring structural and personal resources suggested that while income has a stronger effect on depressive symptoms among Whites, the strength of the relationship between education and better mental health was greater among African Americans, and the effects of education on Black mental health were mediated by mastery and self-esteem (Alang 2014). However, neither of these resources ultimately explained the race paradox in mental health.

Research is consistent that stress is associated to poor mental health. Differential exposure to stress is the major premise of the stress process framework- a prominent theoretical perspective in understanding variability in risks of negative mental health outcomes (Pearlin et al. 1981; Turner and Lloyd 1999). According to the stress process, social context and position shape exposure and response to stressors such as daily hassles,

discrete life events, and chronic strains (Pearlin et al. 1981; Pearlin 1989; Pearlin 1999). Following this framework, group differences in mental health outcomes originate from group differences in exposure to stressors and in access to stress-buffering resources such as social support and personal control. However, even though Blacks are more likely to be exposed to stress with less access to stress-buffering resources, they do not have worse mental health outcomes than Whites.

McLeod (2012) argued that while the focus on social position and resources in the stress process is important, constructions of meanings of stress have been neglected. Brown and Harris (1989) proposed that to assess the correlation between stressors such as negative life events and psychiatric illness, the characteristics, social context, severity and emotional significance of these events must be taken into account. Even after the experience of similar life events, all social groups are not equally vulnerable to mental health problems. Symptom formation is shaped by how the threat of stressful life events is appraised (Brown and Harris 1989). However, most studies that utilize the stress process framework still assume similar measures and meanings of stress for multiple race groups. In addition, while social statuses such as race and social resources determine exposure to stress, they also shape responses to stress and outcomes of stress. The appraisal of stress may vary between settings and populations, suggesting that culture might influence how any potentially stressful event is appraised (Popa, Guillet, and Mullet 2014).There is a need to expand application of the stress process by investigating meanings of stress (McLeod 2012), how culture plays out in the stress process, and how the stress process operates within the context of culture.

This dissertation begins to address this research need by focusing on how culture influences stress and mental health among U.S.-born Blacks or African Americans in a disadvantaged urban neighborhood. It focuses on factors that are specific to Blacks, and that are believed to matter for their mental health. It highlights cultural perspectives on stress and the burden of stress on mental health. This dissertation explores the potential for culture to explain paradoxical mental health findings among African Americans by seeking to understand how culture shapes stress experiences, resources, and expressions of stress outcomes in unique ways.

Culture is a complex and multidimensional concept; it consists of symbols that transmit a shared understanding of behavior, and of how groups perceive and experience the world (Geertz 1973; Swidler 1986). According to the United Nations Educational, Scientific and Cultural Organization (UNESCO), "culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs" (UNESCO, 2001). I use culture throughout this dissertation to refer to values, norms and beliefs that transmit shared meanings and shape daily life – a definition recommended for use in public and mental health research (Cardemil 2010b; Hruschka and Hadley 2008). I also refer to culture as a context or space within which norms, values, and beliefs are shared (Fiske 1992; Gupta and Ferguson 1992) (Fiske 1992; Gupta and Ferguson 1992).

1.2 Purpose of Study

This dissertation explores the role of culture in shaping stress and mental health among African Americans in a poor urban neighborhood. It describes how culture influences the translation of stress into mental health outcomes. I argue that cultural factors such as norms, values and beliefs that embody shared meanings among Blacks may shape the appraisal of stress, influence coping strategies and determine how mental health problems are defined and expressed. Past research has been limited in its explanatory capacity to contextualize complex phenomena around which stress and mental health problems are experienced. The focus on health behaviors and socio-economic resources in understanding the race paradox in mental health does not explore how culturally distinct experiences, shared values, beliefs and norms might facilitate or prevent the translation of stress into poor mental health within and across race groups. Identifying cultural factors that influence the relationship between stress and distress is important in understanding how individuals become vulnerable to, or are protected from common mental health problems.

Culture might influence the appraisal of stressors, serve as a resource that buffers the impact of stress on mental health, and determine how individuals express distress. In this dissertation, I assess whether specific aspects of culture that vary by race explain the race paradox in mental health. I focus on distinctive attributes of U.S. - born Blacks as a social group that might influence how they experience stress and express mental health problems. In particular, I explore contextual features such as community, neighborhood, and shared experiences of stress and common resources that determine the degree to which stress might affect mental health. I assess distinct norms, values and beliefs that

shape appraisal and response to stress, and the expression of stress outcomes in the community. Norms are expectations and informal rules that are shared and understood within a group, and that guide behavior. Values are aspects, principles, or standards that members of a culture treasure, find desirable, and that shape individual priorities. Beliefs are ideologies that embody norms and values, and underlie social processes within a group (Achenbach 2001; Schwartz 1994; Terry, Hogg, and White 1999; van de Vijver, Fons JR, Chasiotis, and Breugelmans 2011). I describe the role of norms, values and beliefs in stress and mental health within a community of U.S. - born Blacks

1.3 Research Objectives

The overall goal of this dissertation is to explore how culture influences the stress process in a community of U.S. - born Blacks living in a disadvantaged neighborhood in a Midwestern U.S. city. I use a mixed methods design to address the following specific objectives:

1: To describe culturally salient sources and characteristics of stress.

Culture plays a role in translating stress into negative mental health by providing the context within which stress is experienced and defined. That is, culture determines whether certain experiences and phenomena are considered sufficiently negative and threatening - sufficiently stressful - to cause psychological distress and interfere with normal functioning. Culture serves as the space in which people also share experiences, expectations, values and beliefs about life. Culture, as a context, includes group resources, hierarchy of needs, group perceptions of these factors, and how they interact to impose challenges to, or enable survival. To address this objective, I identify sources of

stress and the kinds of stressors that are common in the neighborhood. I also describe everyday experiences of stress.

2: To identify culturally salient stress-buffering resources and responses to stress.

To address this aim, I explore how Blacks respond to stress and react to stressors. An important part of assessing how culture influences perceptions and moderates responses to stress is analyzing cultural categories through which stressful events are appraised. Specifically, I explore the role of social conventions such as norms, values and beliefs in influencing responses to stress. I describe what these responses are, and identify culturally significant resources to manage stress in the neighborhood.

3: To identify shared definitions and expressions of mental health problems.

One way by which culture may explain lower prevalence of common mental health problems among Blacks is that Blacks may express symptoms in ways that might not be operationalized in instruments used in community surveys. A content analysis of ethnographic reports of African American experiences of mental illnesses found that about one third of symptoms identified in ethnographic studies did not match what had been operationalized in the Diagnostic Interview Schedule (Heurtin-Roberts, Snowden, and Miller 1997). To assess whether Blacks conceptualize and express psychiatric distress differently from how it is operationalized in surveys, it is important to first determine whether there is a shared construction of distress among Blacks. I explore what mental health problems look like, and whether certain signs or symptoms are considered to be the common indicators of mental health problems among U.S. - born Blacks.

I use ethnography - a qualitative method and Cultural Consensus Analysis (CCA) - a quantitative method, to address all three objectives. Using ethnographic methods, I

describe how Blacks experience stress and distress, and the context within which these are experienced. In the CCA, I assess the degree to which participant beliefs about stress, stress resources and responses, and mental health problems are shared. These methods are employed concurrently in a triangulation approach to increase confidence in findings. This methodological approach offers important insight into typical health services issues, distinct from more traditional health services research methods. It is highly valuable; in fact, this methodology is consistent with priorities of the Patient-Centered Outcomes Research Institute (PCORI) – a program established by the Affordable Care Act (ACA) of 2010 to promote patient-centeredness in research, and to help patients, their caretakers and clinicians to make the best decisions about their health and healthcare (Washington and Lipstein 2011). Decisions about the most relevant and effective interventions cannot be made without evidence-based information that comes from communities served, and that is generated within the context of their viewpoints and preferences (Selby, Beal, and Frank 2012). Accordingly, the research approach in this dissertation facilitates a more central role for Blacks in their assessment of stress and perceptions of mental health. It also elicits objective cultural meanings of stress and ways of expressing distress independent of clinically defined criteria.

1.4 Significance of Study

Previous research using the stress process framework has explored the role of social, personal and structural coping resources in moderating the effects of chronic stressors such as poverty, unemployment, and discrimination on Black mental health (Lincoln, Chatters, and Taylor 2003; Miller, Rote, and Keith 2013). However, no research has explored how culture might serve as a resource in the stress process. In addition, research

on the role of specific cultural factors in the appraisal of stressors and in the expression of psychiatric distress among Blacks is lacking. Much of the prior attention to culture in mental health research has focused on attitudes toward mental health and the expression of symptoms (Earl et al. 2011; Keys et al. 2012; Kleinman 2004; Lange 2002; Mezzich et al. 1999). However, the role of culture in the experience of stress and in shaping responses to stress among disadvantaged African Americans in the community has not been explored. This dissertation is significant in that it begins to address the current research gap.

Furthermore, mental health problems cannot be completely understood at the clinical level. Most people with mental health problems do not seek treatment in health care settings (Alegria et al. 1991; McAlpine and Mechanic 2000; Wang et al. 2005). Moreover, while some people may look to mental health providers for help, individuals are experts in their own experiences of distress. This ethnography will provide insights into meanings of mental health problems, and the role of the cultural context, shared meanings, norms, values, and beliefs in predicting risks of mental health problems among Blacks. So far, lower rates of common disorders in quantitative studies tell a story of resilience among African Americans who are disproportionately exposed to stressors. However, little is known about how this mental health advantage, if objectively true, is attained. The current study begins to address this gap by assessing the role of culture in the race paradox in mental health.

Finally, ethnographic methods will contribute significantly to current understanding of mental illnesses among Blacks. Mental illnesses are currently conceptualized and

measured based on assumptions that are central to Euro-Western psychiatry and might not necessarily capture the experiences of Blacks in the U.S. Research based on quantitatively structured surveys may miss meanings of stress and the cultural factors that shape the experience and expression of psychiatric symptoms that even though are relevant to mental health research, are not operationalized in community surveys. This dissertation provides a description of stressors, how stress is experienced, stress responses, the mechanisms that influence responses to stress and mental health outcomes of stress. As a result, it will have implications for the measurement of common mental disorders in community surveys, and for the usefulness of the cultural formulation interview in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) in the clinical assessment of mental disorders among Blacks.

It is important to note that the goal of ethnographic work is not to generalize observations across a population. Rather, ethnography is concerned with describing and understanding day-to-day life systemically and accurately, and weaving observations into a form that highlights meanings and patterns (Wacquant 2003). The study provides more information regarding health and mental health consequences of chronic stress that is useful in identifying areas for policy interventions, and in informing the delivery of mental health care. The field of mental health within health services research has primarily focused on outcomes including the distribution, evaluation and treatment of mental health problems. This dissertation highlights cultural mechanisms by which these mental health outcomes are produced

Chapter 2

LITERATURE REVIEW

This chapter begins with a brief analysis of some of the existing scholarship that explores culture in relation to the well-being of disadvantaged urban-dwelling Blacks. Next, a summary of the mechanisms by which race affects physical and mental health, and the role that physiological responses to stress play in these relationships is presented. Studies that assess racial differences in psychological distress and DSM disorders are reviewed. I analyze the literature on cultural influences on mental health and cultural models of mental illnesses. I proceed to discuss perspectives about African American culture and mental illnesses from the Black psychology and mental health scholarship. The chapter concludes with an analysis of the stress process framework and its adaptation to develop a conceptual model that guides this dissertation.

2.1. Culture and the Well-being of Blacks

Urban poverty scholars evaluate the role of culture in the daily lives and well-being of Blacks residing in disadvantaged neighborhoods in U.S. cities. This line of research became popular after the emergence of the "culture of poverty" concept. The concept posited that the poor remained in poverty not because of the social and economic conditions that got them there in the first place, but because of low aspirations, disorganization, and unhelpful practices and behaviors - a culture that develops from living in poverty (Lewis 1966; Lewis 1971). According to Lewis (1971), this culture reproduces itself such that a change in structural conditions would not lead to freedom from poverty as long as the culture remains in place. He argues that for upward social

mobility to occur, people living in poverty must adopt a different set of values. Many social scientists have critiqued the culture of poverty theory or provided evidence that counters its arguments (Duneier 1999; Gould 1999; Julius 1987; Leacock 1971; Massey 1990; Newman 2009; Petterson 1997; Small and Newman 2001; Valentine 1968). But most of the work that explores the relationship between culture and poverty seeks to explain why poverty is prevalent in Black urban neighborhoods, debunk myths that Blacks in such neighborhoods are poor because of certain behaviors, attitudes, or values, and to understand how culture helps people to deal with poverty (Harding, Lamont, and Small 2010).

The general scholarship in this area coalesces in assessing whether the idea of culture has helped our understanding of poverty. Concepts such as frames (shared ways of viewing the world), repertoires (universe or glossary of practices beliefs, actions, habits and skills that are summoned at specific instances), narratives (collection of individual experiences and self-conceptions that shape action), and symbolic boundaries (collective identities and experiences that differentiate between two groups), can be used to understand how culture can be applied to studying issues of urban poverty (Harding, Lamont, and Small 2010; Lamont and Small 2008). Harding et al.(2010) demonstrate that scholars of race, culture and urban poverty have typically employed one or more of these cultural concepts in their work.

According to Wilson and Dunbar (1984: 109): “cultural values grow out of specific circumstances and life chances and reflect one’s position in the class structure.” This perspective construes culture as a repertoire of attributes that are indicative of one’s

social location (Wilson and Dunbar 1984). In *The Truly Disadvantaged*, Wilson (1987) asserted that poverty and pathology among Black males were products of joblessness and social isolation, and that "socially pathological behavior" would change if there were structural changes and more opportunities for the "black underclass." It seemed to Wilson that this repertoire of behaviors and strategies were generated by structural factors such as neighborhood poverty. On the one hand, neighborhood disorganization made "ghetto-related behaviors" conventional. On the other hand, the lack of opportunities to improve quality of life made these behaviors necessary for survival (Wilson 1999). While he advocated for structural changes, Wilson has been criticized for not directly confronting the racial hierarchy that helped maintained the subordinate social position of Blacks and for sustaining the notion that socially pathological behaviors are prevalent among Blacks; suggesting that the black underclass might act in ways that make them seem like contributors to their own disadvantage rather than victims of racism (Gould 1999; Nunnally and Carter 2012; Wilson 2009). However, in his relatively recent works, Wilson argued that culture and structure shape and are shaped by racial exclusion of Blacks, and that structure determines the context within which cultural responses to disadvantage are developed (Wilson 2009; Wilson 2010).

In *Code of the Street*, Anderson (1999) observed how disadvantaged youth in inner city neighborhoods in Philadelphia dealt with racism, joblessness and other forms of disadvantage by adhering to a street culture or code. This code upheld rules around the acceptability of violence and aggression as ways of gaining respect and regulating social interactions. The code of the street is "a set of informal rules governing interpersonal public behavior, particularly violence. The rules prescribe both proper comportment and

the proper way to respond if challenged. They regulate the use of violence and so supply a rationale allowing those inclined to aggression to precipitate violent encounters in an approved way"(Anderson 1999: 33). The street code provided a cultural frame or lens through which African American youth in Philadelphia observed and interpreted social life including their actions and those of others.

Anderson also employed culture as a symbolic boundary by distinguishing between "decent" and "street" families. Decent families perceived themselves as hardworking and independent, and were more likely to adhere to mainstream values. Whereas, street families were more likely to adhere to the code of the street, and to employ this code as an aggressive means of socializing their children into the inner city subculture of violence (Anderson 1999). Collective attributes and characteristics that define one group and places it morally above another foster stereotypes (Lamont and Small 2008). Anderson's work on *Code of the Street* has been criticized for making moral judgements about the so-called street families, and for suggesting that their participation in street violence and aggressive behaviors were contributors to neighborhood poverty (Nunnally and Carter 2012; Wacquant 2002).

Rather than focus on the behaviors of Blacks and how these behaviors are associated with poverty, other urban ethnographies have evaluated the extent to which individual experiences with the social structure and systemic barriers interact to impede economic progress among Blacks, and how Blacks make meaning of these circumstances. For example, in *The Minds of Marginalized Black Men*, Young (2006) opposed the claim that cultural values of Black men can be inferred from their day-to-day behaviors and are

removed from structural conditions in which they live. He argued that poor Black men were active agents who embarked on the micro-level processes of meaning making and developed their life prospects based on how they made sense of their experiences, opportunities and constraints. In this ethnography, culture was assessed based on how reality was constructed in narratives. Assessing the role of culture in understanding poverty using individual narratives is important because narratives are central to the construction of group identities and capture shared experiences (Harding, Lamont, and Small 2010).

Young (2006) explained how Black men in Chicago made sense of their current social condition and its implications for their future. One of Young's most prominent findings was that the most socially isolated Blacks whose social history did not go beyond their neighborhood were more likely to blame themselves for their perceived failure to get ahead in life. Whereas, those who had more social history or contact with members of different race groups and socio-economic status had a more macro-structural understanding of their circumstances, and were able to articulate forms of oppression (Young 2006). This finding demonstrates how much the culture of poverty argument can negatively influence the self-evaluation of individuals living in more confined environments with limited resources.

Kelley (1997) strongly critiqued the culture of poverty concept and argued that African American urban spaces should not be erroneously conceptualized as sites for self-destruction and production of norms that encourage laziness, violence, and immediate self-gratification. While researchers described the social conditions of Black urban

spaces, they rarely assessed how structural issues like racism (and police intimidation) destabilized these spaces and maintained ideologies that blame the condition of Blacks on their behaviors and alleged lack of work ethic (Kelley 1997).

Institutional structures and policies play out in ways that further disadvantage Blacks living in urban poverty. A study in yet another disadvantaged Philadelphia neighborhood highlights the overuse of police intimidations, raids and threats of incarceration to monitor the lives of Black men and to obtain evidence used for their subsequent imprisonment (Goffman 2014). It focuses on how Black men make sense of their lives trying to escape arrest or re-arrest, and the impact that being on the run and in constant surveillance has on their families and communities. Culture could be inferred in the processes of meaning making and re-organization of social life around staying away from the police. In *On the Run*, Goffman (2014) portrays Black men as active cultural agents - making decisions such as not applying for state-issued identification, not providing a known address for a job application, and not going to the hospital because these might become resources for surveillance.

Like Anderson (1999), Goffman (2014) describes and categorizes her subjects using boundaries that might foster stereotypes: “dirty” people were wanted by the criminal justice system and their “clean” counterparts were those who had no contact with the justice system. Lamont and Small (2008) caution that the use of categories that distinguish between groups from the standpoint of morality may stigmatize and blame one group for their position and characteristics, and may perpetuate the culture of poverty

concept. In fairness, Goffman's account humanizes the "dirty" people, and emphasizes how criminal justice policies dehumanize them and their families.

If anything, the culture of poverty argument and the body of research it has generated clarifies for researchers that the relationship between culture and poverty is complex, and it is further complicated by the racial structure and disadvantaged position of Blacks in the U.S. Delineating the role of culture in shaping experiences of stress, stress resources and mental health among a Blacks living in urban poverty is even more complex. But this analysis cannot be done without consideration of racism and other systematic barriers that affect the health and well-being of African Americans.

2.2 Race and Health

Race is a not a meaningful biological concept, but a socially constructed system of classification that views certain groups as inherently superior to others based on skin color (Williams, Lavizzo-Mourey, and Warren 1994). Race represents a system of oppression and power relationships that define dominant and subordinate positions in society. Because of the constant reconstruction of the meaning of race in contemporary United States, racial types emerge, are transformed or disappear based on social processes such as mobilization, collective action, and political initiatives that facilitate the assimilation and acceptance of "legitimate" groups into dominant categories (Omi and Winant 2008). Persons belonging to the same racial category are therefore bound together by socially significant physical characteristics that predict social, political, economic, and heath conditions over the life course.

Research has demonstrated that race is an important and independent predictor of health, and that persons who belong to racial minority groups have worse health outcomes than Whites. In the U.S., the largest and most documented health disparities are between Blacks and Whites. At birth, the life expectancy of Whites is about four years greater than for Blacks. Black infants are two times more likely to die in their first year of life than White infants. For seven of the ten leading causes of death, Blacks have higher mortality rates than Whites (Health, United States, 2012). These disparities are also evident in disease-specific morbidity. For example, the incidence and prevalence of fatal coronary heart disease, bacterial pneumonia, lung and colorectal cancers are elevated among Blacks (Burton et al. 2010; Irby et al. 2006; Safford et al. 2012; Underwood et al. 2012). In addition, Blacks have poorer prognosis and treatment outcomes for chronic diseases than Whites (Bhandari et al. 2005; Bruce et al. 2009; Carey et al. 2006; Harris 2001).

Disproportionate poor health among Blacks compared to Whites is not biologically determined. While an arbitrary social status category, race has real life consequences that are evident in health outcomes. Sociologist W.E.B. DuBois writing in the 19th century argued that higher rates of morbidity and mortality among Blacks were primarily due to social factors. Since then, a lot of research has focused on assessing mechanisms by which race affects health. Several pathways have been postulated; the most prominent are socio-economic status and discrimination (Du Bois, William Edward Burghardt and Eaton 1899).

Socio-economic status (SES) is used to appraise access to resources by individuals or groups. SES has been conceptualized as the relative position of individuals or groups on a hierarchical social structure, based on access to and control of wealth and power. SES affords prestige, and increases the ability to create and consume valuable goods (Adler and Newman 2002; Mueller and Parcel 1981; Oakes and Rossi 2003). Individual socioeconomic status is frequently operationalized as income, education and occupation (Braveman et al. 2001; Shavers 2007). Income influences health outcomes by increasing social capital, affording access to healthy foods and better housing, improving quality of life, and by directly providing the means to purchase healthcare (Gerdtham and Johannesson 2004; Kawachi et al. 1997; Lynch et al. 2000; Lynch et al. 1998; Marmot 2002). Education, in addition to improving earning potential, increases health literacy, provides life skills that are important for maintaining good health, and facilitates the diffusion and utilization of health information (Cutler and Lleras-Muney 2010; Ross and Wu 1996; Winkleby et al. 1992). Persons with high status and prestigious occupations are likely to have higher income, education and more control over their life circumstances. Low status jobs disproportionately expose individuals to occupational hazards such as toxic substances and work injury, and persons working under such conditions are less likely to have the full range of work benefits that are important for health (Batinic et al. 2010; Costa 1996; Kivimaki et al. 2005; Mustard, Vermeulen, and Lavis 2003; Parkes 1999).

Disadvantages associated with socio-economic status accumulate over the life course (Shuey and Willson 2008). The lack of cumulated assets including wealth reduces the capability to rely on, and utilize a stock of available resources that matter for health.

Blacks have significantly less wealth than Whites (Conley 2001; Oliver and Shapiro 2006). As a result, even at similar levels of education, Blacks have increasingly worse health over the life course (Shuey and Willson 2008). On average, Blacks have lower SES compared to Whites, and this explains some of the racial disparities in health (Farmer and Ferraro 2005; Williams and Jackson 2005; Williams et al. 2010).

Racial residential segregation increases clustering of disadvantage with Blacks more likely to live in impoverished neighborhoods (Charles 2003; Massey 1990; Williams and Collins 2001a). The effects of neighborhood SES on health are beyond the effects of individual socio-economic characteristics because neighborhoods influence individual behavior and increase individual risks factor (Macintyre, Ellaway, and Cummins 2002; Macintyre 2007). The lack of social capital, collective efficacy, and recreational facilities reduce positive social interaction and increase crime rates (Browning and Cagney 2002; Cohen et al. 2006; Sampson, Raudenbush, and Earls 1997). Crime, physical disorder, vacant housing and toxic waste that characterize such neighborhoods may directly cause disease, lead to risky health behaviors such as substance use or prevent regular exercise, thus compromising overall health (Aneshensel and Sucoff 1996; Cohen et al. 2006; Fullilove et al. 1998).

Research has established that having fewer socio-economic resources at the individual and neighborhood levels is associated with higher rates of impairment, disease and mortality (Bell et al. 2006; Braveman et al. 2010; Kawachi and Berkman 2003; Subramanian, Acevedo-Garcia, and Osypuk 2005). Research is also consistent that racial disparities in SES play an important role in producing racial disparities in health

(Hayward et al. 2000; Livingston 1994; Williams and Collins 1995). Yet, there are Black-White health disparities within every level of SES (Kahn and Fazio 2005; Smith and Kington 1997; Williams 2005; Williams 2003). One explanation for this observation is that racial discrimination reduces the ability of Blacks to translate socio-economic resources into good health (Browning, Cagney, and Wen 2003; Crimmins, Hayward, and Seeman 2004; Shapiro and Kenty-Drane 2005).

Discrimination is a second mechanism postulated to produce race differences in health. Discrimination is defined as "actions or practices carried out by members of dominant racial or ethnic groups that have a differential and negative impact on members of subordinate racial and ethnic groups." (Feagin and Eckberg 1980, Pp.1-2). Anti - Black discrimination is pervasive across the U.S. (Feagin 1991). Although racial discrimination causes poor health among Blacks by restricting access to socio-economic resources and quality health care (Karlsen and Nazroo 2002; Williams and Collins 2001b; Williams and Mohammed 2009), racial discrimination is also a significant psychosocial stressor that affects health directly by elevating rates of several health conditions including cardiovascular conditions and low birth weight (Krieger and Sidney 1996; Williams, Neighbors, and Jackson 2003). The experience of discrimination also leads to a range of negative emotions and feelings, including distress, anger, fear, and thwarted aspirations. These reactions could produce endocrine, cardiovascular, neurological and immunological responses that consequently affect health (Broman 1996; Kiecolt-Glaser et al. 2002; Krieger 2000; Mays, Cochran, and Barnes 2007; Shonkoff, Boyce, and McEwen 2009). In addition to the direct health outcomes of stress, Williams and Mohammed (2009) suggest that stress and negative emotions that result from racial

discrimination can cause victims to engage in unhealthy coping behaviors including substance use, and disengagement in healthy activities such as regular exercise.

Blacks' poorer physical health outcomes are therefore largely due to disproportionate exposure to stress that result from racism and low SES (Williams et al. 1997; Williams and Mohammed 2009; Williams 2012). Persons of lower SES reside and work in more stressful environments, experience more economic strain, lack job security, face more life disruptions, and lack sufficient resources to deal with these hardships (Brunner 1997; Pearlin et al. 2005). In addition to SES-related stress, racial discrimination is similarly a chronic stressor that is experienced regularly over the life course by African Americans (Ong, Fuller-Rowell, and Burrow 2009).

2.3 Physiological Responses to Stress and Racial Disparities in Health

Stress is implicated in health disparities because Blacks disproportionately experience stress that increases disease burden. Biologically, stress refers to any challenge or threat to physiological equilibrium (Goldstein and Kopin 2007; McEwen and Stellar 1993). Stress causes disequilibrium to physiologic functioning and elevates the activity levels of several physiological systems, leading to system "wear and tear". The repeated activation of certain physiological mechanisms in response to chronic ongoing stress is known as allostasis, and the resulting deterioration or "wear and tear" of body systems is known as allostatic load (McEwen 1998). The allostatic load represents the negative physiological impact of stressful events and experiences. Allostasis emphasizes the need for physiological systems to be adaptable to various external demands or stresses. According

to this concept, stress responses are variable, and are informed by prior experiences (Sterling 2004).

Despite the specificity of stress responses that result from variability in stressors, previous experiences and individual physiologic functioning, the biological mechanisms that underlie the system of responses are consistent and involve the autonomous nervous system (ANS). Once stimulated by a stressor, the ANS immediately releases mediators (neurons and chemicals) that elevate physiological activities and that lead to biological and behavioral changes including accelerated heart rate, increased respiratory rate, sweat production, and increased vigilance (Berntson, Cacioppo, and Quigley 1993; Chrousos and Gold 1992). The hypothalamus responds by releasing arginine-vassopressin (AVP) and corticotropin-releasing hormone (CRH), both of which activate the hypothalamic-pituitary-adrenal (HPA) axis. The HPA axis is the system of feedback interactions between the hypothalamus, the pituitary gland, and adrenal glands. In addition to activating the HPA axis, AVP stimulates the kidneys to increase absorption of water and contraction of the blood vessels, elevating blood pressure. CRH causes the anterior pituitary to release corticotropin which then stimulates the production of cortisol by the adrenal glands (Miller and O'Callaghan 2002; Tsigos and Chrousos 2002).Cortisol's primary function is to restore equilibrium after an acute stress and an increased physiological activity. Cortisol regulates the metabolism, circulation, immune response, and memory (Sapolsky, Romero, and Munck 2000; Tsigos and Chrousos 2002).

When stress becomes prolonged or recurrent, elevated rates of chemical mediators such as cortisol, and the continuous burden exerted on the body through response processes

(allostatic load) can lead to chronic conditions such as stroke and other cardiovascular diseases, diabetes, depression, post-traumatic stress disorder, obesity, autoimmune disorders, cognitive impairment, accelerated aging, and death (Djuric et al. 2008; Flier, Underhill, and McEwen 1998; Geronimus et al. 2006; Hellhammer et al. 2004; McEwen 2007; McEwen 2008; Mello, Andrea de Abreu Feijó de et al. 2003). Therefore, chronic stressors precipitate lower levels of health by increasing allostatic load. So far, studies find higher allostastic load among Blacks than Whites (Chyu and Upchurch 2011; Duru et al. 2012; Geronimus et al. 2006; Wallace et al. 2013). This reflects differences in exposure to stress (Juster, McEwen, and Lupien 2010; Stewart 2006). Racial differences in allostatic load also account for some of the observed disparities in various health outcomes (Borrell, Dallo, and Nguyen 2010; Carlson and Chamberlain 2005; Geronimus et al. 2006; Szanton, Gill, and Allen 2005).

2.4 Race and Mental Health

Race is hypothesized to affect mental health through mechanisms similar to how it influences physical health. First, institutionalized racism leads to an overrepresentation of Blacks in lower SES, interrupts upward socio-economic mobility, and fosters racial residential segregation leading to poorer living conditions and limited access to resources among Blacks (Aneshensel 2009; Williams and Williams-Morris 2000). Second, perceived discrimination, as a chronic stressor, can induce emotional and physiological responses that adversely affect mental health (Fischer and Shaw 1999; Landrine and Klonoff 1996; Sellers et al. 2003). A third mechanism postulated to specifically affect mental health is that internalization of negative racial stereotypes among Blacks can lead

to negative self-evaluations that are damaging to mental health (Taylor and Jackson 1990; Taylor, Henderson, and Jackson 1991; Williams and Williams-Morris 2000) .

Based on experiences of racism and lower SES that disproportionately expose Blacks to stressful live events, chronic strains and hardships over the life course, Blacks are expected to have worse mental health than Whites. However, only few studies have found evidence of poorer mental health among Blacks. Most of the research on race and mental health suggests similar or lower rates of mental health problems among Blacks compared to Whites.

Research on race differences in mental health have focused on two types of mental health outcomes: distress or depressive symptoms and DSM disorders. The DSM is the handbook of conditions and symptoms intended to facilitate consistent diagnosis of mental disorders by mental health professionals, especially in the U.S. The DSM-V defines a mental disorder as a "clinically significant disturbance cognition, emotion regulation, or behavior that indicate a dysfunction in mental functioning that are usually associated with significant distress or disability in work, relationships, or other areas of functioning" (American Psychiatric Association, 2013, p. 20). Disorders are characterized by a dysfunction caused by the inability of internal psychological systems to function naturally (Horwitz 2007; Wakefield 1992). Distress is considered a normal response to stressful social circumstances and is expected to subside after the stressor goes away or when an individual manages the stressor (Horwitz 2007; Mulder 2008; Schwartz 2007). The DSM does not distinguish between symptoms of distress that are normal responses to stressful circumstances from mental disorders (Wakefield, 1992).

However, distress can be an underlying symptom of disorder, especially if experienced in excess of what is deemed appropriate within the context, or continues well after the cessation of the stressor that precipitated the distress (Mulder 2008; Wheaton 2007).

While DSM disorders are dichotomous categories on which clinicians rely to make treatment decisions (Kessler 2002), symptoms of distress provide a better assessment of the mental health consequences of social structures and social arrangements, especially for persons who fail to meet the cut off scores for dichotomous diagnostic categories (Horwitz 2002; Horwitz 2007). Although these two outcomes (i.e. distress and disorders) are distinct, there is evidence of a strong positive link between them (Payton 2009), and it is important to explore how social factors influence outcomes across the mental health continuum (Mirowsky and Ross 2002).Table 2.1 summarizes major studies that assessed racial differences in symptoms and DSM disorders.

Distress and Depressive Symptoms: As shown on Table 2.1 (organized in the order discussed), there has been a number of studies of race differences in mental health using community samples from specific states. One of the early studies using a sample of Florida adults found that both urban and rural-dwelling Blacks had higher rates of psychological distress than their White counterparts (Neff 1984). Controlling for SES eliminated race differences in distress in the urban sample but not among rural-dwellers. In contrast, in the Detroit Area Study (DAS), there were no racial differences in psychological distress although Blacks had lower levels of education and income. Furthermore, Blacks in the DAS were more likely to experience chronic discrimination, greater levels of financial strain and more frequent stressful life events such as unemployment, major illness and physical assault. Yet, they reported less chronic stresses

like dealing with aging parents or problems balancing life and work. Although there was no racial variation in psychological distress, Blacks reported lower quality of life than Whites (Williams et al. 2007). Other community based studies using state-based samples from Colorado and North Carolina found more depressive symptoms among Blacks compared to Whites. In the Colorado study, higher scores on the Center for Epidemiologic Studies Depression Scale (CES-D) among Blacks were partially explained by the fact that Blacks had more difficulty meeting their basic needs (Plant and Sachs-Ericsson 2004). Lack of basic needs and lower education explained the Black-White disparity in CES-D scores in the North Carolina sample which consisted of persons 65 and older (Sachs-Ericsson, Plant, and Blazer 2005).

Findings from studies using nationally representative data reveal overall higher rates of psychological distress and depressive symptoms among Whites compared to Blacks. However, Blacks in the National Alcohol Survey who were between the ages of 30 to 39 years had greater odds of elevated CES-D scores than Whites, while middle class and unemployed Blacks had lower odds. The researchers suggested that higher depressive symptoms among Blacks aged 30 to 39 were a result of greater exposure to stressful life events compared to Whites at that point in the life course (Jones-Webb and Snowden 1993). In contrast, odds of severe psychological distress were higher among Whites in the National Survey on Drug Use and Health (NSDUH) in both unadjusted and adjusted models (Harris, Edlund, and Larson 2005). Findings from the National Health Interview Survey (NHIS) also suggest lower unadjusted odds of psychological distress among Blacks (Bratter and Eschbach 2005; Roxburgh 2009).

DSM Disorders: The first population-based estimates of racial disparities in DSM disorders were based on the Epidemiological Catchment Area (ECA) study. Study sites were New Haven, Baltimore, St. Louis, Durham, and Los Angeles, although estimates were weighted to provide national estimates. The Diagnostic Interview Schedule (DIS) was used to assess DSM-III disorders. Somervell et al. (1989) assessed socio-demographic differences in the prevalence of major depression using the ECA study. With the exception of Black women age 18-24 that had higher six month prevalence of major depression than White women, they found that six month and lifetime prevalence of major depression was higher among Whites compared to Blacks (Somervell et al. 1989). Higher rates of a range of a range of DSM-III affective disorders among Whites compared to Blacks have also been reported (Weissman et al. 1991).

A later study using ECA data further confirmed these initial findings. Blacks had significantly lower rates of most DSM-III disorders including major depression, dysthymia, obsessive-compulsive disorder, drug and alcohol abuse or dependence, antisocial personality, and anorexia nervosa. The researchers found no Black and White differences in schizophrenia but Blacks had higher rates of phobias and somatization (Zhang and Snowden 1999). When the analyses were restricted to the Los Angeles sample of the ECA study, results suggested similarities in the prevalence of most disorders, except for schizophreniform, somatization and drug dependence where Blacks had higher rates than Whites (Zhang and Snowden 1999).

The National Comorbidity Survey (NCS) baseline is a nationally representative congressionally mandated survey that was fielded between 1990 and 1992, and was the first nationally representative mental health survey in the U.S. that used a fully structured

research diagnostic interview (Composite International Diagnostic Interview – CIDI) to assess revised DSM-III disorders. Findings from the NCS have consistently revealed lower risks and prevalence of disorders among Blacks. Based on the NCS, Kessler et al. (1994) found that compared to Whites, Blacks had significantly lower rates of affective disorders (major depressive episode, manic episode, dysthymia or any affective disorder). There were no racial differences in the 12 month prevalence of anxiety disorders. Similar findings from the NCS were later reported with lower lifetime risks of mood disorders among Blacks (Breslau et al. 2005). More recently lower odds of major depression and dysthymia were found among Blacks in the NCS baseline (Rosenfield 2012).

The NCS was replicated (NCS-R) between 2001 and 2003 to study trends in a wider range of variables and depth of topics than those assessed in the original NCS.The NCS-R used DSM-IV categorization of disorders. Studies using this data lend support to the race paradox in mental health. The prevalence of lifetime major depressive disorder was significantly lower among Blacks compared to Whites and there were no differences in 12 month prevalence (Kessler 2005). Blacks also had lower risks for and prevalence of generalized anxiety disorder and social phobia compared to Whites. However, they had higher life time prevalence of bipolar disorder (Breslau et al. 2006).

The Health and Retirement Study (HRS), a national longitudinal survey of U.S. adults age 50 and older, used a shorter version of the CIDI to assess DSM disorders. Findings from the 1996 cohort that consisted of adults between the ages of 54-65 suggested initial higher odds of major depressive episode (MDE) among Blacks, but after SES indicators and other health measures were adjusted, Whites had higher odds of MDE than Blacks

(Dunlop et al. 2003).These findings were explained by higher rates of life-threatening diseases, functional limitations, and uninsurance among Blacks.

The National Survey of American Life (NSAL) is the most recent, comprehensive and nationally representative survey on mental health in the U.S. In this survey, DSM-IV disorders were assessed using the CIDI. Results from the NSAL showed lower lifetime and 30 day prevalence of major depressive disorder among African Americans compared to Whites, and no racial differences in 12 month prevalence (Williams et al. 2007). There were no racial differences in the likelihood of having at least one mood or one anxiety disorder in the past 12 months (Mouzon 2013). Similarly, findings from the National Survey on Drug Use and Health (NSDUH) suggest lower rates of DSM-IV disorders among Blacks (Harris, Edlund, and Larson 2005).

From the review, exceptions to the paradox are found in a few state-based studies showing higher rates of distress among Blacks compared to Whites (Neff 1984; Plant and Sachs-Ericsson 2004; Sachs-Ericsson, Plant, and Blazer 2005) and in an age-restricted sample of adults (54-65 years) where Blacks had initial higher rates of MDE (Dunlop et al. 2003).The majority of studies provide strong evidence that Blacks do not have elevated rates of mental health problems in spite of their disadvantaged social position and disproportionate exposure to stress.

Table 2.1: Summary of studies that assessed racial differences in distress, depressive symptoms and common DSM disorders in community-based samples

Author(s) and year	Data or Sample	Outcome measure	Findings about race	Evidence of Paradox
Neff 1984	Rural/urban Florida survey	Psychological distress assessed using Warheit items	Blacks were more likely than Whites to have psychological distress.	No
Williams et al 1997	Detroit Area Study	Psychological distress assessed and Psychological wellbeing assessed using self- rated overall life satisfaction	No significant racial differences in psychological distress but lower rates of psychological well-being among Blacks compared to Whites.	No for psychological well-being, yes for SPD.
Sachs-Ericsson, Plant and Blazer, 2005	Duke Established Populations for Epidemiologic Studies of the Elderly (EPESE)	Center for Epidemiologic Studies Depression Scale (CES-D)	In the unadjusted model, African Americans had higher CES-D scores than Whites. Adjusting for SES indicators led to higher CES-D scores among Whites.	No
Plant and Sachs-Ericsson 2004	Colorado Social Health Survey	CES-D, DSM III Major depression, assessed using the Diagnostic Interview Schedule (DIS)	Higher CES-D scores among Blacks and slightly higher prevalence of depression among Blacks.	Yes
Jones-Webb and Snowden 1993	National Alcohol Survey	CES-D	Overall, Blacks had lower risks of depressive symptoms than Whites in the middle and lower classes. However, Blacks between the ages of 30-39 had higher risks of depressive symptoms than their White counterparts.	Yes
Harris et al. 2005	National Survey on Drug Use and Health (NSDUH)	SPD (K-6) and at least one DSM IV disorder assessed using the CIDI-SF	African Americans had lower rates of SPD and were significantly less likely than Whites to have a DSM IV disorder. Differences became more pronounced after adjusting for SES.	Yes

Author(s) and year	Data or Sample	Outcome measure	Findings about race	Evidence of Paradox
Bratter and Eschbach 2005	National Health Interview Survey (NHIS)	Severe Psychological Distress (SPD) using the K-6 instrument	Similar rates among Blacks and Whites. Adjusting for SES led to lower rates among Blacks.	Yes
Roxburgh 2009	NHIS	SPD using the K-6 instrument	No overall race differences in the unadjusted model. However, Black women did worse especially in low resource sample but did better than Black men, White women and White men in in resource rich sample.	Yes
Somervell 1989	Epidemiological Catchment Area Study	DSM III major depression, assessed using DIS	Overall, Blacks had slightly lower 6 month and lower life time prevalence of major depression. When stratified by gender and age, Black women ages 18-24 had slightly higher 6 month prevalence of major depression.	Yes, somewhat
Weissman et al. 1991	Epidemiological Catchment Area Study	DSM III affective disorders assessed using DIS	Blacks had slightly lower rates of affective disorders than Whites but these differences where only significant in the 30-64 age range.	Yes
Zhang & Snowden 1999	ECA study and then just the Los Angeles sample of the ECA only	DSM III disorders using DIS	In the full ECA sample, Blacks had lower rates of major depressive episode, major depression and dysthymia than Whites. There were no racial differences in schizophrenia, and Blacks had higher rates of phobias and somatization. In the LA sample, there were no racial differences in prevalence of disorders, except for schizophreniform and somatization where Blacks higher rates.	Yes

Author(s) and year	Data or Sample	Outcome measure	Findings about race	Evidence of Paradox
Kessler et al. 1994	National Comorbidity Survey (NCS) baseline	DSM-III disorders assessed using the Composite International Diagnostic Interview (CIDI)	Compared to Whites, Blacks had lower rates of affective disorders (major depressive episode, manic episode, dysthymia or any affective disorder). No Black-White differences of in anxiety disorders were found.	Yes
Breslau et al. 2005	NCS	DSM III mood and anxiety disorders assessed using the CIDI	Blacks had lower lifetime and 12 month prevalence of mood and anxiety disorders.	Yes
Rosenfield 2012	NCS	Major depression and dysthymia combined, assessed using the CIDI	Blacks had lower rates of depression, overall. Black women had lower rates of depression than White women in both higher and lower education group. Rates in White men only exceeded rates in Black men in lower education level.	Yes
Kessler et al. 2003	NCS-Replication	Major depressive disorder using the CIDI	Prevalence of lifetime major depressive was lower among Blacks compared to Whites. However, there were no racial differences in 12 -month prevalence.	Yes
Breslau et al. 2006	NCS-R	DSM IV disorders assessed using the CIDI	Blacks had lower risks for and prevalence of depression, generalized anxiety disorder, & social phobia compared to Whites. However, they had higher prevalence of bipolar disorder compared to Whites.	Yes
Merikangas et al. 2007	NCS-R	Bipolar Disorder assessed using the CIDI	No racial differences in Bipolar Disorder.	Yes

Author(s) and year	Data or Sample	Outcome measure	Findings about race	Evidence of Paradox
Dunlop et al. 2003	Adults (54 to 65) in the 1996 cohort of the Health and Retirement Study (HRS).	Major depressive episode, assessed using the CIDI-SF	Initial higher odds of major depressive episode among Blacks, but after SES and health status indicators were adjusted, Whites had higher odds of major depressive episode than Blacks	No
Williams et al. 2007	National Survey of American Life	Major depressive disorder assessed using the CIDI	The lifetime prevalence of major depressive disorder was higher for Whites than African Americans. No differences existed in 12 month prevalence, but 30-day prevalence was slightly greater for Whites	Yes
Mouzon 2010	NSAL	Any DSM mood and anxiety disorder assessed using CIDI, and CES-D scores	Whites had higher CES-D scores than Blacks and there where nor racial differences in the odds of having any mood or anxiety disorders	yes

2.5 Culture and Mental Health

Culture has been conceptualized as a highly dynamic system of meanings existing in material and intangible form, is learned, shared and most importantly, essential for survival (Eshun and Gurung 2009; Kao, Hsu, and Clark 2004). It encompasses all aspects of life and inherently affects health. Health is subject to varying interpretations produced by cultural influences on individual perceptions. Specifically, culture shapes health beliefs and behaviors, affects the nature of health communication, and interferes with the

delivery of health care and management of health conditions (Bhui and Dinos 2008; Kreuter and McClure 2004; Kreuter and Haughton 2006; Landrine and Klonoff 1992; Maillet and Spollett 1996; Shaw et al. 2009; Thomas, Fine, and Ibrahim 2004). Culture also encompasses political ideology; a marker for values and beliefs such as personal and social responsibility, religiosity, and civic participation, that might be associated to good health (Cockerham et al.2006; Pacheco and Fletcher 2014; Subramanian and Perkins 2010). Cultural characteristics and values such as materialism or individualism can also act as health determinants by influencing perceptions of socio-economic inequality. Eckersley (2006) argues that culture moderates or amplifies the health effects of SES. In groups with a more individualistic culture, the costs of being poor are accentuated because of the perceived lack of social support, the widening gap between the rich and the poor, and the weakening of social bonds. However in communalist and collectivist cultures, poverty does not necessarily compromise health potential (Agbayani-Siewert, Takeuchi, and Pangan 1999; Castillo 1997; Marsella 2003). Consequently, cultural differences might predict differences in health.

Mental health is a complex topic regardless of cultural differences. Within the context of culture, assessing mental health is even more complex. There are several ways by which culture influences mental health. First, culture shapes the experience of symptoms of mental distress. Second, it determines how individuals express symptoms within the context of their cultural norms. Third, it dictates how symptoms are interpreted and diagnosed. Finally, it influences treatment and outcomes of treatment (Agbayani-Siewert, Takeuchi, and Pangan 1999; Castillo 1997; Marsella 2003). For example, in some cultures, not all negative emotions are considered harmful or undesirable; guilt is

important in collectivist cultures and serves to control individual behavior for the community as a whole (Eid and Diener 2001). Similarly, there is evidence of intercultural differences in "distress thresholds" in relation to how parents assess mental health problems among their children (Weisz and Weiss 1991). Furthermore, in certain cultural settings, some symptoms are perceived and accepted as normal expressions of emotions in response to specific social conditions while in other cultures, they may be seen as signs of illness (Karasz 2005; Kirmayer, Young, and Hayton 1995).

Furnham and Malik (1994) assessed cultural differences in beliefs about depression and found that Asian women were more likely than British women to think about depression as the lack of control and the inability to "pull it together". The inability to be in control of things in one's personal life was considered self-indulgent and contrary to the traditional Asian value of privileging the family over the individual. Although older Asian women scored higher on measures of depression, they were less likely than their British counterparts to report knowing someone who has been depressed, suggesting that cultural norms dictated silence regarding depression and mental health problems (Furnham and Malik 1994).

Furthermore, cultural differences in expressions of depression were found in a sample of American and Australian men. While Australian men were more likely to report feelings of total lack of meaning and diminished sex drive, American men often expressed milder depressive symptoms such as irritability or hypersomnia (Lange et al. 2002). Mental and emotional problems are expressed as physical problems in some cultures (Angel and Guarnaccia 1989; Kirmayer and Young 1998; Kleinman 2004; Waitzkin and Magana

1997). Findings from an ethnography in China suggest cultural variation in depression. The authors argued that it was not culturally acceptable for Chinese to report feeling sad. As such, depression was expressed as a physical and not a psychological condition, and experiences of depression were often described as pain, fatigue, boredom and dizziness (Lee, Kleinman, and Kleinman 2007). Culture influences mental health because the experiences of mental health and symptoms of mental illness vary across culture.

The fields of medical anthropology and cultural psychiatry use two divergent frameworks to evaluate the significance of culture in mental health. These are cultural universalism and cultural relativism. While universalism considers all mental disorders to occur within every culture, sometimes as variations of the same illness, relativism holds that mental disorders are unique to a cultural context and can only be understood within that setting (Agbayani-Siewert, Takeuchi, and Pangan 1999; Kirmayer, Young, and Hayton 1995; Mezzich et al. 1999).

On one hand, cultural universalists argue that culture is an exogenous force that influences behavior as well as mental health. According to this framework, both mental health problems and culture can be studied objectively and distinctly, without assuming that one is inherently a part of the other (Berry and Sam 1995). Universalism asserts that the biological similarity of the human race is strong evidence that psychopathology is in effect, similar. It also asserts that slight variations in expressions of the same mental disorder are caused by cultural differences that are exogenous to the disorders (Patel and Winston 1994). Western psychiatry is essentially universalist in its quest for identifying objectively defined categories that can be explained by biological similarities within and across cultures.

On the other hand, cultural relativists argue that culture, behavior and mental health problems are endogenous to one another (Berry and Sam 1995). Rather than looking for similarities in disorders across cultures, relativism seeks to understand distress and mental health problems in their own context. There are no standard outlines or set of symptoms that would be manipulated and validated in a new population to measure or assess psychiatric problems. From a relativist perspective, the meanings and ways of expressing psychiatric distress are assessed from the cultural context or discourse within which distress is experienced (Sam et al. 2002).

Cross-cultural psychiatrists use a universalistic approach to validate constructs of distress generated within one context in another context (Canino and Alegría 2008; Patel and Winston 1994). An obvious limitation of this method is that psychiatric instruments will only capture problems that are consistent with symptoms that have previously been classified and are known to exist within the original context. Kleinman (1987) argues that when cross-cultural psychiatry is reduced to comparisons of symptom appearance, culture becomes superficial, and biological changes are highlighted as the main causes of disorders. However, disorders have always been defined and characterized by changes in the patterns and cultural acceptability of symptoms, rather than biological or physiological changes (Kleinman 1987).

Mental health providers are increasingly recognizing the role of culture. As a result, considerations on the relevance of culture in mental health and illness have been made in the DSM. The DSM strives to provide consistent, objective and scientifically validated guidelines for classifying mental disorders and to perform individual diagnosis. With clinicians increasingly working with patients from diverse backgrounds and in

multicultural settings, the validity of the DSM as a classification system for mental disorders has been questioned (Kirmayer 1991; Kleinman 1987; Lewis-Fernandez and Kleinman 1995; Maser, Kaelber, and Weise 1991; Mezzich et al. 1999; Thakker and Ward 1998). Growing awareness of cultural influences on mental health and illness led to the addition of an outline for cultural formulation in the fourth edition of the DSM (DSM-IV-TR). This outline consists of a series of questions to be used by the provider to assess cultural factors that might be relevant for diagnosis and treatment. However, the cultural formulation guideline has been criticized as a culture-blind, universalist system of classification where cultural variables are considered as clinical afterthoughts to symptoms whose manifestations may vary cross-culturally (Canino and Alegría 2008; Harper 2001). From a relativist perspective, the DSM-IV failed to take into consideration the notion that boundaries between normal behavior and pathological behavior are different across cultures, and as such, the DSM has the tendency to classify a set of behaviors as a disorder even in the absence of internal dysfunction (Lewis-Fernandez and Kleinman 1995; Wakefield, Pottick, and Kirk 2002). Significant progress has been made towards toward assessing culture in the DSM-V. The cultural formulation interview (CFI) was designed to help clinicians and researchers to capture cultural differences in perceptions of disorders, variations in the expression of symptoms, as well as cultural influences on help-seeking (Aggarwal 2013; Alarcon 1995; Mezzich et al. 1999). Although research is yet to evaluate utilization of the CFI and its effectiveness in understanding the role of culture in the expression of symptoms, a remarkable step in the DSM-V is that it does not assume that all symptoms fit into established biomedical categories of mental disorders.

In this dissertation, I adopt a strong relativist approach to culture and mental health. While culture influences the perceptions of stress, the impact of stress on mental health, and how mental health problems are conceptualized and expressed, culture is not exogenous to psychiatric distress. Culture inevitably defines mental illness and serves as the context in which disadvantaged African Americans experience distress. Most studies on cultural influences on mental health have focused on the clinical encounter, exotic cultures and cross national cultural variations (Alegría et al. 2012; Earl et al. 2011; Furnham and Malik 1994; Keys et al. 2012; Lange et al. 2002; Lee, Kleinman, and Kleinman 2007). There are no studies on how shared meanings, contextual factors, norms, values and beliefs among Blacks shape the experience of stress and the definition and expression of mental health problems.

Research about the effects of John Henryism on Black mental health highlights the potential of culture as a frame through which stress is experienced. John Henryism (J.H.) is the term used to describe a persistent high-effort coping response to stressors, and has been conceptualized as a cultural adaption for African Americans that is often summoned to foster hard-work, self-reliance and freedom, overcome new forms of oppression, but has long term negative consequences on health (James 1994). Neighbors, Njai and Jackson (2007) used data from the NSAL reinterview to assess whether J.H., as a coping mechanism, may help explain racial differences in symptoms of depression. They found no significant relationship between J.H. and symptoms of depression among African Americans. However for Whites, the active high-striving efforts to cope with stress were damaging to mental health (Neighbors, Njai, and Jackson 2007). Data from the NCS suggested an association between J.H. and good mental health for African Americans,

Hispanics and Whites even though the strength of these associations did not vary by race (Kiecolt, Hughes, and Keith 2009). Among African American samples, J.H. was associated with better mental well-being and reduced depressive symptoms (Bronder et al. 2013; Matthews et al. 2013; Sellers, Neighbors, and Bonham 2011). These findings are informative and lend support to the claim that mental health outcomes do not only depend on exposure to stressors. However, research on J.H. and Black mental health only focuses on how people cope with stress. There is a significant lack of knowledge about how stressors are appraised and talked about in daily life, how they shape mental health outcomes, and what mental health and mental illnesses mean.

2.6 Models of Mental Illnesses

Genetic bio-medical models dominate psychiatry in the U.S. These models link mental illnesses to abnormalities in brain function, hormonal imbalance and other biological causes (Leo 2004). Accordingly, a dysfunction that affects mental functioning is as much of a disease as a dysfunction that affects physical functioning. The causes of mental illnesses in bio-medical models are genetic, chemical and physical changes in the brain. Bio-medical model adherents argue that these changes can be recognized by specific symptoms that distinguish mental illnesses from other illnesses, or one particular mental illness from another (Schnittker 2008; Tyrer and Steinberg 2006; Whooley 2010).

Insofar as mental disorders are perceived through the lens of bio-medical models of illnesses, the universalist assumption holds that symptoms should be similar across race and culture. Yet, not all people subscribe to bio-medical models of illness. For example, Schnittker, Freese, and Powell (1999) found Blacks less likely to subscribe to genetic or

bio-medical models of mental illnesses. A proposed explanation of why African Americans may be more skeptical of genetic models of mental illness is that early studies of racial differences in health, cognitive ability, good and criminal behavior, often took an extreme hereditarian stance that supported anti-Black policies. As a result, the similarity between bio-medical models of mental illnesses to the reasons previously advanced to support Black racial inferiority might lead Blacks to reject biomedical/genetic models of mental illnesses (Schnittker, Freese, and Powell 1999).

A second common model of mental illnesses is the behavioral model. According to this model, mental illnesses are fundamentally problematic or maladaptive behaviors that are learned through positive social sanctioning and modeling (Tyrer and Steinberg 2006). People learn behaviors by seeing other people perform them, and by performing the behaviors themselves with no negative sanctions. Maladaptive behavior stems from the inability to adapt to changing or unfamiliar circumstances (Sroufe et al. 2000; Tynes, Utsey, and Neville 2008). As with the genetic bio-medical models, Blacks are less likely to subscribe to the behavioral model because it seems to suggest that their communities are deviant and non-conforming to prescribed behavioral patterns of dealing with challenging environmental circumstances (Schnittker, Freese, and Powell 1999; Schnittker 2003).

The psychodynamic model, a third model of mental illnesses, identifies feelings as the cause of problematic thinking and behavior (Tyrer and Steinberg 2006). These feelings may or may not be known by the individual, but have formed through interpersonal relationships at critical stages in the life course. This model is based on the work of Sigmund Freud, and was the first attempt to explain mental illnesses using psychological

vocabulary (Gallop and O'Brien 2003; Haslam 2000). Given that this model looks retrospectively at problematic interrelationships, it might suggest that family units are dysfunctional, thereby blaming mental illnesses on communities affected. In their study, Schnittker et al. (1999) found that compared to Whites, Blacks were more likely to reject models of mental illnesses that blame family upbringing.

A fourth model, the socio-cultural, takes a broader view of psychiatric disorders. Mental illnesses are best understood in the context of social and cultural forces such as metropolitan or rural settings, gender, ethnicity, attitudes, norms, and beliefs that determine normal behavior (Dohrenwend 1975; Hunter and Schmidt 2010; Tyrer and Steinberg 2006). Social and cultural forces are presumed to be the most important determinants of mental disorders and are intrinsically linked to behavior. This model is similar to the psychodynamic model in that it views mental disorders as caused by factors outside of biology. Nonetheless, an important difference is that while psychodynamics construes mental disorders as personalized experiences caused by unknown or unconscious feelings, the socio-cultural model emphasizes that mental disorders are defined by group norms, and are generally caused by unfavorable environmental factors.

Finally, the biopsychosocial model is the broadest and most eclectic perspective of mental illnesses. According to this model, social, cultural, environmental, biological and psychological factors all determine mental illnesses through reciprocal influences (Engel 2004; Pilgrim 2002). Given the complex reality of mental illnesses, reducing disorders to simple and single causes is erroneous. Public conceptions of mental illnesses are increasing shaped by the biopsychosocial model, although some mental illnesses are considered more biological and others more social. Schizophrenia, for example, is

attributed to biological and chemical imbalance; depressive disorders are attributed to dealing with chronic stressors of daily life; drug and alcohol dependency are believed to be caused by the bad decisions of individuals (Martin, Pescosolido, and Tuch 2000). With differential categorization, people will always seek explanations that align with their preferences (Ghaemi 2009; Kirmayer 2005). A possible implication is that models of mental illnesses might determine whether people acknowledge symptoms as problematic or whether they are comfortable enough to report them on community surveys.

2.7 African Americans, Culture and Mental Illnesses

Perceptions of mental illnesses cannot be generalized across African Americans as one cannot assume that all Blacks conceptualize stress, react to stress, and experience or express distress in similar ways. Important variations exist based on socio-economic status, region of residence, religiosity, family and community resources, social capital, age, and gender. While I acknowledge these variations, I analyze the literature on culture and Black perceptions of mental health and illnesses on a broader less-nuanced level. There has not been much research in this area, and most of the hypothesized mechanisms by which some cultural norms, values and beliefs affect Black mental health have not been tested.

In their book evaluating the role of contemporary Africentric values and beliefs on Black psychology in the U.S., Belgrave and Allison (2009) argue that contrary to a Eurocentric focus on illness and disease, Blacks are more likely to emphasize the existence of disharmony, and the need for harmony rather than the need for treatment. Mental illnesses are perceived as a form of disharmony between the individual, their social

context, community values and God (Belgrave and Allison 2009). Azibo (1989) proposed mental 'disorders' must be understood in terms of mental 'order', and should be considered as a deficiency in an expected state of psychological functioning. Azibo further argued that mental health reflects achievement in the psychological and behavioral spheres of life such that daily functioning is consistent with the collective mind of Blacks, with nature, the universe and with God (ya Azibo 1989). This notion of harmony or the lack thereof does not matter only for the individuals concerned. Mental illnesses, or "pathology in the individual is presumed to be reflective of dysfunction in the larger social group and context…" (Myers et al. 2003). As a result, when an individual has a mental illness, there is an underlying assumption that the community to which they belong might not have performed its functions fully and efficiently.

Perhaps the most established finding in cultural psychiatry is that culture affects the expression of psychiatric distress (Agbayani-Siewert, Takeuchi, and Pangan 1999; Kleinman 2004; Kleinman 1987). Blacks might be more likely than Whites to somaticize mental disorders (Robins and Regier 1991). In a content analysis of ethnographic reports of African American experiences of mental illnesses, Heurtin-Roberts, Snowden & Millier (1997) found that African Americans were more likely to express distress through physical complaints such as 'lump in the throat', and 'chest pain'. More quantitative studies have lent support to the hypothesis that somatization is particularly common among African Americans (Jones-Webb and Snowden 1993; Snowden 1999).

In a piece comprising of stories and interviews of Blacks regarding mental health, Poussaint & Alexander (2000) highlight the issue of symptom expression, and what symptoms or their absence might mean for the mental health of Blacks. For example, in

response to a suicide, an interviewee states: “There are so many questions facing blacks where mental health is concerned. We need to know what the term “well” means for us. We also need to know who is defining these terms, and whether or not our particular experiences are being addressed. We need to begin remaking medical and mental health institutions in our own image.” (p. 28). It is important to know what psychiatric distress means, what it looks like among Black communities, and the specific cultural factors that influence distress.

Jackson and Sears (1992) proposed the Africentric worldview is an important framework for understanding stress among African Americans. Cultural values shape cognitive appraisals of stress, define stressful situations and guides behaviors. An important Africentric value is that material and non- material (spiritual) aspects of life are equally esteemed. This is contrary to the Eurocentric ideal of privileging the material over the spiritual (Jackson and Sears 1992). The ideology of equal value and balance between material and spiritual aspects of life might contribute to lower prevalence of psychiatric symptoms among Blacks. By not placing as much value on material things, economic disadvantage might appear to have a lesser effect on Black mental health than on the mental health of Whites.

Another important Africentric value is the emphasis on group protection, group survival, collective responsibility and interdependence. These values are exact opposites of western ideologies of survival of the fittest, autonomy and independence (Jackson and Sears 1992; Myers et al. 2003). Given that mental illnesses are conceived by some as weaknesses and a reflection of group shortcomings, part of group protection might be the

denial of distress. Acknowledging distress might threaten the survival of the group by weakening its structure and function.

Many people with mental illnesses do not speak of, or acknowledge distress because it will change the way members of their community perceive them (Poussaint and Alexander 2000). The appraisals of other members of the Black community matter more for African Americans than appraisals from the society at large (Jackson and Lassiter 2001). By keeping feelings of distress personal or treating such feelings as non-existent, some Blacks uphold certain cultural views of mental illnesses. As Poussaint and Alexander (2000) assert, acknowledging that one experiences such symptoms might be "…seen by the larger community as showing signs of weakness or, even worse as 'putting his business in the street.'''(p. 26). Cultural values and the social expectations that most African Americans have of themselves might account for lower prevalence of disorders in community surveys of mental health.

Collectively, the material reviewed shows that race, stress and culture affect mental health. However, there is a paucity of research regarding cultural influences on Black mental health. There are only postulations about how some Africentric values, social expectations, and beliefs about mental illnesses might shape the experience and acknowledgement of mental health problems among Blacks. My dissertation evaluates these postulations to identify shared meanings, values, norms and beliefs that are relevant to Black mental health and to describe the mechanisms by which they influence mental health. Given that the stress process is the leading framework for understanding the social origins of mental health, I explore how the stress process operates within the context of

culture to determine the mental health of African Americans in disadvantaged neighborhoods.

2.8 The Stress Process

Over the past several decades, the stress process has been the dominant framework used to explain the social origins of mental health and the social distribution of mental health problems. Stressors, stress moderators (resources) and stress outcomes are the three fundamental components of the stress process. This framework focuses on how the sources of stress, resources for coping with stress, and the outcomes of stress vary across different groups in the population (Pearlin et al. 1981; Pearlin 1989). Stressors, resources and outcomes are interrelated to form a process, and are mutually dependent. Specific resources or a combination of resources are needed to cope with particular kinds of stressors. The experience of one stressor may beget another stressor through the process of stress proliferation. In the same way, the presence or level of one resource may influence the impact of another. Consequently, within this framework, any particular outcome is associated to specific arrangements of stressors and resources (Longest and Thoits 2012; Pearlin et al. 1981; Thoits 1994).

Stressors: Stressors are experiential situations, factors or conditions that produce stress. Stress research focuses on three main types of social stressors: life events, chronic strains, and daily hassles. Stressors have been expanded to include sudden traumas (Thoits 1995; Wheaton 1999; Wheaton et al. 2013). Life events are discrete events that even though are unexpected, are rooted within people's social conditions. To be considered a stressful life event in the stress process, an event must be acute and separate from any ongoing

circumstances in which the event might be embedded. A common example of this kind of stressor is the destruction of one's home by a hurricane (Avison and Turner 1988; Pearlin 1989).

Chronic strains are more enduring ongoing circumstances that require management and adaption over a long period of time, and may be related to several social roles. Examples include living with chronic illnesses, discrimination, and poverty (Avison and Turner 1988; Thoits 1995; Wheaton 1999). Daily hassles are frustrating or distressing demands and circumstances that are easily a part of daily life, but that do not fall within the conceptualization of stressful events or chronic strains. Examples include noise and traffic problems, preparing meals, and long waits (Thoits 1995; Wheaton 1999). Traumas refer to unexpected discrete stressors with a strong and serious impact, for example, sexual assault (Wheaton et al. 2013). In general, chronic strains have a stronger link to mental health because of they represent more enduring and unresolved struggles (Avison and Turner 1988; McGonagle and Kessler 1990; Taylor and Turner 2002).

Resources: Resources in the stress process refer to the collectivity of actions, interactions, and views that are employed to cope with stress. The most prominent resources are coping schemes, personal resources and social support (Pearlin 1989; Pearlin 1999; Thoits 2010; Thoits 1995). Coping refers to strategies that enable psychological and behavioral changes in response to stress. These strategies may aim at preventing the continuous experience of stress, altering the circumstances that cause stress, averting reoccurrence of the stressor, or may adjust interpretation of the stressor to something less threatening (Kessler, Price, and Wortman 1985; Taylor and Stanton 2007). Although

coping is a stress resource in its own right (Wheaton 2010), the possession of high levels of mastery, self-esteem and social support facilitate coping (Pearlin 1989; Thoits 1995).

Mastery and self-esteem are the most studied personal resources in the stress process. Mastery refers to the sense of personal control over one's life chances (Pearlin and Schooler 1978). Self-esteem reflects the degree to which individuals approve or disapprove of themselves (Rosenberg 1965). In relation to the stress process, individuals with a high sense of mastery and high levels of self-esteem are well-equipped to engage in rigorous problem-solving, are resilient, and believe in their ability to overcome stressors (Rosenfield, Lennon, and White 2005; Thoits 1994; Thoits 1995; Turner and Avison 1992; Turner and Roszell 1994; Turner and Avison 2003). Social support is a significant resource in the stress process. It refers to physical and emotional sustenance derived from social networks, and includes perceived, instrumental and informal forms of assistance. In addition to material support, the perception of a helpful and dependable support system may cause individuals to appraise potentially negative events and chronic strains as less threatening (Cobb 1976; Kessler, Price, and Wortman 1985; Thoits 1986; Thoits 1995; Turner 1999).Therefore, social support and relationships are stress moderators and improve mental health (Kiecolt, Hughes, and Keith 2008; Mouzon 2013; Mouzon 2014; Wheaton 2010).

Stress outcomes: Stress outcomes are manifestations of stress and are fundamental to the stress process. Stress research largely focuses on outcomes of stress that manifest as mental health problems and that have strong social causes (Pearlin 1989). Examples of these outcomes include psychological distress, depression, anxiety, social functioning,

and alcohol and drug abuse. Although most of the research that employs a stress process formulation address single stress outcomes, the exploration of multiple outcomes is encouraged as manifestations of stress are bound to vary with social position, stress exposure and stress resources (Aneshensel 1999; Pearlin 1989).

The three components of the stress process – stressors, resources and outcomes - are contingent on social status or position. Pearlin (1989) states that "the structural contexts of people's lives are not extraneous to the stress process but are fundamental to that process." (p.242). He adds that the social structure and people's location within it affect stressors, resources, and outcomes - concepts that form the core of the stress process. Specifically, social conditions, statuses, and roles determine exposure to stressors, coping resources that people utilize, and the particular outcomes they experience. Accordingly differential exposure to stressful experiences and differences in access to stress-buffering resources are the primary ways by which race, ethnic, gender, and other social class inequalities in mental health are produced (Aneshensel, Rutter, and Lachenbruch 1991; Thoits 2010; Turner and Lloyd 1999).

People with the most disadvantaged and marginalized statuses are more likely to be exposed to stressors. The kinds of stressors that are strongly associated to less privileged social statuses are those that continue over the life course, such as poverty and discrimination (Pearlin et al. 2005). These stressors are expected to be severely damaging to the mental health of persons who belong to race and ethnic minority groups because the minority status itself serves as a stressor. Among African Americans in particular, discrimination and poverty are significant sources of stress (Clark et al. 1999; Schulz et

al. 2000; Williams and Jackson 2005).There is also evidence that these factors increase the risk of mental health problems (Aneshensel, Rutter, and Lachenbruch 1991; Aneshensel 2009; Hudson 2005; Kessler, Mickelson, and Williams 1999; Krieger et al. 2011; Landrine and Klonoff 1996; Schnittker 2012). Based on the stress process perspective, African Americans should have worse mental health than Whites.

Yet, as reviewed, the best available epidemiological studies suggest African American mental health to be similar or better than the mental health of Whites (Breslau et al. 2006; Kessler et al. 1994; Kessler 2005; Williams et al. 2007). One way of understanding this paradox is to explore the core components of the stress process among a community of African American within the context of culture. Although earlier stress research emphasized meanings of stressors and the relationship between the social context and components of the stress process (Aneshensel and Pearlin 1987; Brown and Harris 1989; Caspi, Bolger, and Eckenrode 1987; Pearlin 1989; Pearlin 1993), stress researchers have not fully explored these factors. Most of the research that explores the relationship between the social context and stress have focused on social statuses and roles within social institutions (Clark et al. 1981; Longest and Thoits 2012; Noh and Avison 1996; Ong, Fuller-Rowell, and Burrow 2009; Pearlin et al. 1990; Pearlin, Aneshensel, and Leblanc 1997; Pinquart and Sörensen 2003; Turner and Wood 1985). In this dissertation, I explore how culture: shared meanings, norms, values and beliefs shape core components of the stress process. These aspects of the social context have been highly overlooked in stress research.

To measure stress exposure, stress researchers frequently use a life events checklist, or a similar set of chronic stressors and strains believed to be associated with the social status under investigation. For example, to investigate racial differences in physical and mental health, Williams and colleagues (1997) assessed stress exposure using the count or occurrence of stressors such as racism, problems with a close family member, hassles at work, serious illness or injury, assault, robbery, and unemployment.

While this approach to measuring stressors is useful, it is void of experiences and meanings that are likely to vary across racial groups, and that provide the mechanism by which these stressors affect health. George and Harris (1989) argue that an event is a stressor and affects mental health only to the degree that it is appraised as threatening. I propose that culture, defined as shared understandings and social conventions, determines particular kinds of stressors that African Americans are exposed to. Consistent with the work George and Harris (1989), I argue that culture determines the degree to which particular events are considered stressful and threatening.

Research on stress-buffering resources focusses on psychosocial stress moderators such as mastery, self-esteem, religiosity and social support (Bierman 2006; Bovier, Chamot, and Perneger 2004; Lincoln, Chatters, and Taylor 2003; Pudrovska et al. 2005; Rosenfield 2012; Schieman and Pearlin 2006; Schieman 2008) even among African Americans (Lincoln, Chatters, and Taylor 2003; Miller, Rote, and Keith 2013). However, to understand the race paradox in mental health, there is the need to focus on stress resources that are unique to African Americans. I argue that cultural values, beliefs and

expectations are resources that may prevent the translation of stress into poor mental health. A goal of this dissertation is to identify these cultural factors.

Stress research that focusses on among African Americans explores pre-selected stress outcomes such as depression or psychological distress assessed using standardized instruments (Cutrona et al. 2005; Lincoln, Chatters, and Taylor 2003; Sellers et al. 2003). However, the symptoms listed on instruments that assess specific stress outcomes may not be the most common ways by which African American express these outcomes (Heurtin-Roberts, Snowden, and Miller 1997). I argue that culture determines how African Americans define and express stress outcomes.

In sum, the stress process does not exist in a vacuum but operates within a cultural context that confers the identity of a 'stressor' on certain events and experiences, and influences reactivity to stress. Culture expands the list of resources that can be employed during exposure to stress and that prepare people to deal with stress. Culture influences how people perceive and express stress outcomes. Unfortunately, little attention has been given to the role culture in the stress process. It is important to explore how culture shapes the three core components of the stress process, and how this might help us to understand why African Americans, with significantly greater exposure to what we know to be stressors, have similar or better mental health than Whites.

2.9 Conceptual Model

The main focus of this dissertation is to explore the role of culture in shaping the mental health of African Americans in disadvantaged neighborhoods. Specifically, I assess cultural processes and mechanisms that imbue the complete stress process: stressors,

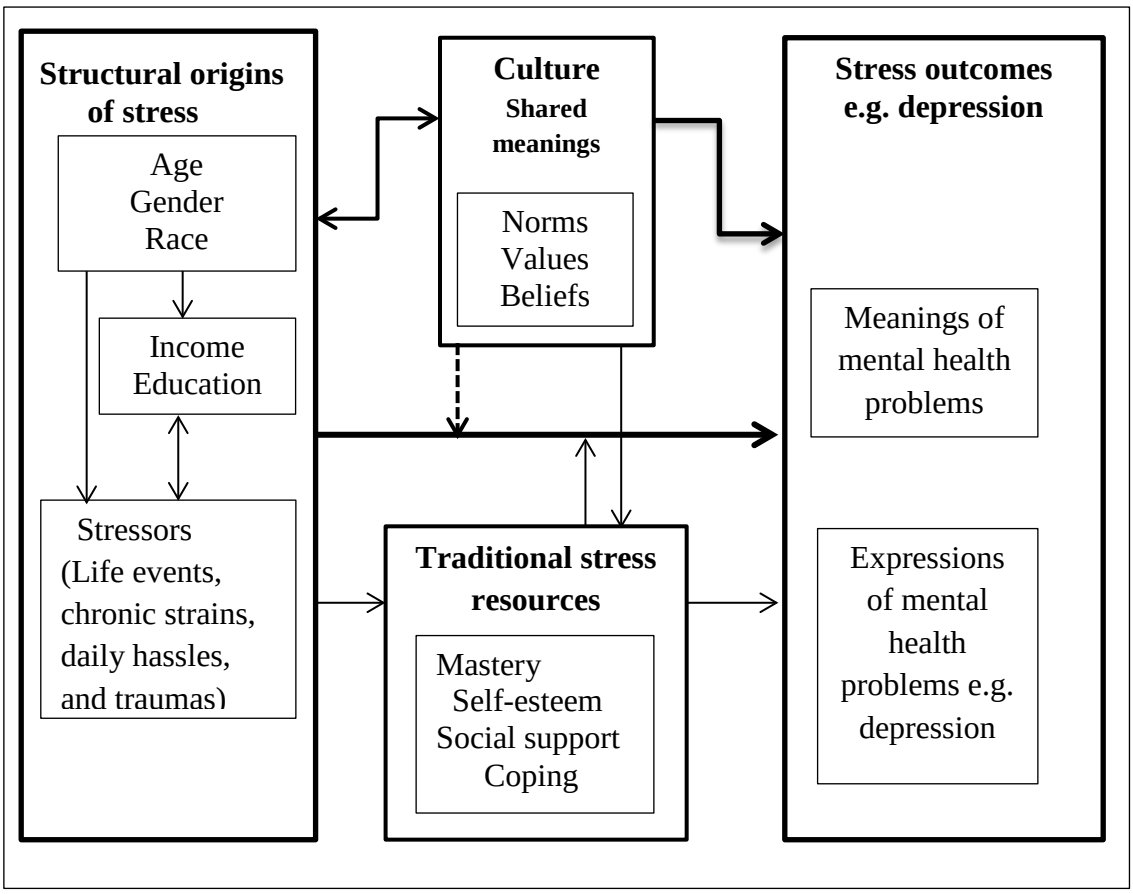
mental health problems, and resources that lie on the causal pathway between stress and mental health problems.

This dissertation is guided by the relationships diagrammed in Figure 2. The model represents theoretical assumptions and empirical findings about race, socioeconomic disadvantage and mental health within the stress process. More importantly, it highlights culture as a context within which components of the stress process play out, and as a resource that mediates and moderates the effects of stress on mental health. While the concept of culture has almost lost a specific meaning because its scope is constantly widened, I focus on how shared meanings that embody social conventions might determine exposure to and appraisal of stressors, stress responses, and definitions and expressions of mental health problems.

The primary theoretical assumption in this model is that individual socio-economic characteristics of African Americans in disadvantaged neighborhoods are caused by, or are at least associated with broader structural, historical, economic and political circumstances of Blacks in the U.S. All these occur within a cultural context that provides meanings to individual experiences. Among Blacks, there is heterogeneity that results from factors such as gender, age, individual experiences of race and SES (Celious and Oyserman 2001; Shaun and Andrew 2008). These factors affect individual and group exposure to stressors as well as access to traditional stress resources. These attributes are also directly associated with mental health as hypothesized by the stress process and other theories of social stratification.

This system of relationships operates within the context of culture. In addition, culture intervenes in the relationship between stress and mental health in two possible ways. First, it would provide meaning to stressors and shape the appraisal of stressors. Culture will mediate the effects of stress because stressors are perceived as threatening to mental health only through the lens of culture. Second, culture will moderate the impact of stressors on mental health by providing cultural ways of dealing with stress. Values, expectations, and beliefs, might also increase vulnerability to psychiatric distress. As a result, the degree to which stressors affect mental health would depend on values, social expectations and belief systems (Brown and Harris 1989; Chambers et al. 1998; Jackson and Sears 1992; McLeod 2012).

Figure 2: Conceptual Model of Cultural Influences on Black Mental Health



Culture does not only determine whether mental health problems are experienced, it shapes the meanings people give to their mental health experiences, and provides a glossary of words that guide the communication of symptoms.

Based on this model, I use ethnographic and quantitative methods to describe culturally salient stressors and stress resources. I also explore the role of shared meanings and social conventions in influencing the appraisal of stressors, responses to stress, and the meanings and ways of expressing depression among African Americans. In the conclusion, I analyze how culture might explain the race paradox in mental health. I discuss the relevance of culture in understanding the translation of stress into poor mental health and in the measurement of common mental disorders in epidemiological surveys, and in providing effective mental health care for African Americans.

Chapter 3

METHODOLOGY

Assessing the role of culture in experiences of phenomena such as stress and mental health problems requires the use of methods that in addition to assessing objective realities, would unpack the more subjective experiences of daily life (Creswell 2012; Mays and Pope 1995; Whitley and Crawford 2005). I conduct this study using the triangulation model of mixed methods research. This model has been explained in detail elsewhere (Creswell 2009; Creswell et al. 2003) but it essentially involves the use of both qualitative and quantitative methods to answer research questions and improve confidence in findings.

I gather and analyze both qualitative and quantitative data concurrently to assess the role of culture in the mental health of African Americans. Qualitative methods can expose and improve our understanding of variation in phenomena, and how causes and their outcomes may be expressed in ways that may not be possible using standardized instruments (Nastasi and Schensul 2005). Furthermore, qualitative methods are more suitable for describing how cultural contexts and categories shape life experiences, and capture meanings and experiences of stress and distress using data collection techniques that are different from traditional health services research methods. I use ethnographic methods to generate descriptions of stressors, resources, stress responses, and ways of expressing mental health problems. These methods focus on identifying expectations and cultural values that are upheld and shared, and that underlie attitudes towards stress, and the expression of outcomes of stress. I also employ cultural consensus techniques to

quantitatively estimate the degree to which beliefs about stressors, resources, and definitions and expressions of mental health problems including depression are common or shared in a community of low-income Blacks.

3.1 Ethnography

Ethnography is the process of capturing naturalistic situations of everyday life by working with people in other settings or cultures; observing, listening and asking questions that shed light on the phenomenon of interest (Atkinson and Hammersley 1994; Atkinson et al. 2001). Ethnography is informed by the interpretive tradition, and it involves the systematic application of carefully selected methods to assess and understand people and their practices both in their context and within a broader social context (Pollner and Emerson 2001; Sanday 1979). In contrast to methods that are explicitly controlled by the researcher, ethnographic fieldwork requires reflexive observation and active participation in naturally occurring situations (Emerson 1987; Emerson 2001a).

Describing daily lives, activities and phenomena of interest are important, but the ethnographer's overarching tasks are to analyze and interpret observations such that meanings can emerge. Ethnography strives to assess how people make sense out of life, the kinds of activities and practices that group members collectively engage in, and the knowledge and beliefs that provide meaning and coherence to these practices (Emerson 1981; Geertz 1973). Ethnographers are expected to be deliberate in selecting the field site(s) and in positioning themselves within that context so that observations will be appropriate for answering the questions under investigation (Emerson 2001).

Kunda (2013) identified four main components of ethnographic research: “observing people's activities, talking with people willing to answer questions about their life, collecting texts of various sorts produced, preserved, displayed and consumed by the people one is studying, and devising ways of keeping a comprehensive, detailed and reasonably legible record of all of this.” (p. 14). However, ethnography is not a linear process that goes from data collection through data analyses to findings and interpretation of findings. It is an ongoing engagement with theory and the literature, and a constant interaction between the research question(s), data collection, data analyses and interpretation; an intricate system of processes that enable the transition from describing mundane observations of everyday life to theoretically relevant patterns and interpretations (Emerson 2001b; Kunda 2013).

Fieldwork is synonymous to ethnography for many researchers, and it also refers to the primary method of data collection in ethnographic inquiry (Whitehead 2005). Ethnography or fieldwork requires the researcher to be fully immersed in ongoing activities with a group, and be familiar with the socio-cultural dynamics of the group, or spend considerable time in areas where persons being studied routinely interact, or where phenomena of interests are evident (Agar 1996; Emerson 1987; Whitehead 2005). Fieldwork may involve observations without participating in community activities, participant observation, informal conversations, informal interviews, structured and in-depth interviews, and personal documents such as participant journals (Atkinson and Hammersley 1994; Burgess 2002; Whitehead 2005).

Ethnographic methods have been used extensively in various disciplines to study a wide range of topics. One of the earliest ethnographies in mental health was the study of patients with severe mental illnesses in a New York psychiatric hospital (Goffman 1961). Since then, ethnography has been used to study various aspects of mental health and illnesses among different groups of people. Some examples include the assessment of efficient HIV policy interventions among persons with mental illnesses in Brazil (Wainberg 2007), ethnic patterns of drug use and survival among heroin injection users in San Francisco (Bourgois et al. 2006), and substance use among persons with mental illnesses in New Hampshire (Alverson, Alverson, and Drake 2000). Ethnographic methods have also been used to assess idioms of distress (Keys et al. 2012), perceptions of schizophrenia, experiences of depression (Lee, Kleinman, and Kleinman 2007) and meanings of continuity of care among mental health service users (Ware et al. 1999). In these studies, ethnography facilitated the evaluation of experiences and meanings that would otherwise not be assessed using purely quantitative research methods.

In this dissertation, ethnography presents a strong potential for generating rich cultural information about Black life in relation to mental health and mental illnesses. From a relativist perspective, mental health and illnesses are highly cultural in nature (Sam et al. 2002). The ethnographic inclination to record and make sense of the way of life of a group, the construction of reality, and shared perceptions and experiences of phenomena make ethnography a valuable method in mental health research (Quimby 2006). Furthermore, an analytical strength of ethnography is its ability to uncover and explain discrepancies between accounts of behavior and behaviors themselves (Khan and

Jerolmack 2013). Ethnography is therefore useful in addressing these kinds of biases that are common in mental health surveys.

3.2 Cultural Consensus Analysis

Ethnographic methods as described in the preceding section are typically used to capture cultural attributes of lived experiences, and to provide rich contextual descriptions of everyday life and experiences. While valid in their own terms, qualitative forms of data produced using these methods are hard to evaluate. Ethnographers often find it challenging to estimate conflicting cultural information from various participants, and to confidently draw conclusions about the cultural or shared nature of the phenomena studied (Romney, Weller, and Batchelder 1986).

Cultural Consensus Analysis (CCA) facilitates estimation of the degree to which cultural beliefs are shared within a group, and the degree to which individuals know or report these beliefs (Romney, Weller, and Batchelder 1986; Weller 2007). CCA enables researchers to describe and evaluate the distribution of cultural knowledge and beliefs within and across groups in an objective way. According to Romney, Weller and Batchelder (2007), the main idea in cultural consensus theory "is the use of the pattern of agreement or consensus among informants to make inferences about their differential competence in knowledge of the shared information pool constituting culture." (p. 316). Using CCA, group beliefs can be estimated from a series of individual responses to questions or statements regarding a phenomenon of interest.

When researchers have no specific hypotheses or "culturally correct answers" to the questions under investigation, CCA provides an empirical method for inferring answers

from individual data. Using factor analysis of informants as variables, CCA estimates the level of individual knowledge of cultural beliefs based on the agreement in responses between individuals. This agreement is also known as informant competency. Individual competence scores are the factor loadings, and they tell how well responses from each informant correspondent with the aggregate group response or *truth*. Therefore, the factor loadings for each informant represent their correlation or agreement with the latent construct or shared cultural knowledge. Cultural consensus is established when there is a single factor solution, or when the first factor accounts for most of the variance (Romney, Batchelder, and Weller 1987; Weller 2007).

Cultural consensus is both theory and methodology. Theoretically, it formalizes the notion that culture is shared, and that culturally correct information can be inferred from the knowledge or cognitive constructs of individuals who share a similar culture. Methodologically, cultural consensus can be systematically applied to a variety of topics, once some assumptions are met (Romney, Weller, and Batchelder 1986; Romney 1999). The first assumption is that informants share a cultural reality or come from a common culture. Second, CCA assumes that responses to questions are independent and informants must provide answers without consulting other informants. Third, each set of questions for which culturally correct answers are sought must represent only one topic or domain. Items must be homogeneous and the knowledge of items should be consistent (Romney, Weller, and Batchelder 1986).

CCA has been used alone and in combination with other methods to understand within and across group variations in cultural models, causal attributions, experiences and

expressions of different mental health problems (Baer et al. 2003; Barg et al. 2006; Dressler, Balieiro, and Santos 1998; Dressler et al. 2007; Lynch and Medin 2006; Martinez Tyson et al. 2011). For example, Martinez Tyson et al. (2011) explored cultural models of depression among Latino immigrants in Florida and found strong cultural agreement on perceptions of symptoms of depression. Somatic and emotional symptoms such as aches, tiredness, sadness and isolation were shared indicators of depression among the Mexican, Cuban, Columbian and Puerto Rican samples. Exploring stress, resources, stress responses and mental health problems specifically in a community of low-income African Americans using CCA is appropriate because it facilitates a more central role for Blacks in the assessment of their perceptions of these concepts. It also elicits objective cultural meanings of stress and ways of expressing mental distress independent of professionally defined criteria.

3.3 Data Sources and Data Collection Methods

Ethnography: Ethnographic data were collected through a twelve-month fieldwork in a predominantly Black cluster of neighborhoods in a Midwestern city. Henceforth, I will refer to this cluster of neighborhoods as Upper Lake Heights (ULH). Although time in the field in and of itself does not constitute a good ethnography, twelve months provided sufficient time needed to build relationships, collect data on context, processes and meanings, and to gain understanding of these data (Wolcott 1987; Wolcott 2005). I spent approximately 20 hours per week walking on the streets, meeting people in parks, hair salons, at bus stops, riding busses, and attending several dozen church events and services, community meetings and funerals, while making important contacts and building relationships with ULH residents who gave me access into their private spaces

including their homes. During the period of the field work (February 2014 to January 2015), discussions and protests about police harassment of young Black men were rampant across the country, and in ULH.

Spradley (1980) describes two main observational categories for collecting data in qualitative research: observing without engaging and observing while engaging. The former refers to observing and describing phenomena through a keen sense of awareness as if all the observations are answers, and the process of observation is equivalent to finding the questions for which answers are observed. The latter category entails participant observation with engagement in activities to gain an emic perspective of the context, and to assess and experience the social-cultural dynamics (Spradley 1980). I started my fieldwork by observing and maintaining a regular presence in ULH. I began taking part in community activities aimed at increasing awareness of social problems that plagued ULH and the resources to address them. Activities included community meetings and volunteering to help with events at various locations in the neighborhood. Participation in these activities helped build rapport with individuals who worked for or collaborated with institutions doing community work in ULH such as churches, libraries, and non-profit organizations. These contacts helped me to understand some of the issues in the community from an institutional perspective, informed me about potentially dangerous areas, and provided safety tips for interacting with persons in these areas. Most of my field work, however, was at bus stops and on major streets considered to be dangerous spaces in ULH. At these sites, I made key contacts who were relatively more vulnerable to stress and familiar with street life in ULH than were my institutional contacts. They gave me access to even more marginalized spaces by allowing me to

shadow them. They vouched for me and recruited some of their peers to provide me with information that was relevant to this work.

I was honest about my research objectives to all of my key contacts. To more casual acquaintances and relationships, I revealed my intentions as a researcher depending on the level of personal interaction, the nature of activity or the subject of discussion. For example, when very personal information was shared such as mental health diagnosis, I would disclose my identity as a researcher, and ask the participant if they were willing to speak more, or if I could use the information they had already shared for my work. Most of the time, ULH residents were willing to speak more, although most were more comfortable speaking in general terms about mental health than about their personal experiences with mental health. Other times, knowing that I was a researcher made some residents to become more calculated about what they would say. Others adjusted their hair and clothes, or fixed their make-up to present themselves in ways they perceived would be desirable.

In most of my interactions, I employed informal unstructured interviews and conversational descriptive interviews. Informal unstructured interviews are essentially unplanned conversations that the ethnographer has with group members. Conversational descriptive interviews, even though informal and unstructured, are based on the ethnographer's plans to ask questions specific to their inquiry in the course of a conversation (Bernard 2011).These questions emerged from previous observations and are part of the iterative process in ethnography. I structured them to elicit cultural information needed to answer my research questions. When I observed activities and

behaviors, I asked questions about what was going on and why, I evaluated the physical, social and cultural spaces within which activities or behaviors occurred, and identified any cultural categories present in the setting. Discussions around stress, resources and outcomes flowed more naturally after objectively stressful events had happened in ULH such as a shooting at a bus stop or a robbery. Because residents were more open about their physical health conditions, I built on the information shared about themselves or others to structure conversations and informal interviews around mental health. More examples of the types of information I elicited and the prompts that were used to assess different components of the stress process are included in Appendix A.

Cultural Consensus Analysis (CCA): CCA is appropriate to estimate agreement, the degree to which meanings of stressors, ways of responding to stress and meanings of mental health problems are shared. Data for CCA were obtained in two stages. The first stage employed a free-listing exercise in which a total of 98 individuals participated. Participants were asked to list all the things they thought caused stress, common ways of dealing with stress, things that came to mind when they heard the words “mental health problems” and words or phrases that have been used to describe a person who has had depression or that came to mind when they heard the word “depression”. Not all 98 participants were willing to respond to all four questions, most responded to two. Four categories of items: 1) Sources of stress, 2) Common resources and responses to stress, 3) Indicators of mental health problems, and 4) Indicators of depression were created.

The residents who participated in the free-listing exercise were selected using convenience and purposive sampling. It was convenient in that I relied on participants’

availability in places I had access to during the ethnography. It was purposive in that a participants' age was estimated as 18 or older and they could speak and understand English. More importantly, maximum variation sampling, a type of purposive sampling technique in which respondents are chosen to be as different from each other as possible (Sandelowski 1995), was employed. This technique ensured that a wide variety of participants were involved in obtaining items for CCA. For example, in addition to gender and age variation, some participants were selected at street corners, on the bus, at restaurants, libraries, churches, or in community events. A paper and pencil/pen were available to a handful of participants who preferred to write their lists by themselves. For most participants, I wrote down the words and phrases as they were stated. A set of stressors was generated from the free-listing exercise. Similarly, a set of stress responses, and a set of meanings of mental health problems and depression were generated. A minimum of twenty items in each category are recommended to obtain better consensus estimates (Weller and Romney 1988; Weller 2007). In the categories of stressors, resources, mental health problems and depression, twenty six, twenty five, twenty eight and another twenty six items were obtained, respectively.

In the second phase of CCA, a purposive and convenient sample of forty key informants rated the importance or cultural significance of items that were listed by a minimum of 10 percent of participants in that specific category during the free-listing exercise. 19 items were retained for sources of stress, 19 for stress responses and resource, 16 for mental health problems, and 21 for depression. Romney, Weller and Batchelder (1986) and Weller and Romney (1988) have demonstrated using sample size calculations that 20-30 respondents are sufficient to gain a clear picture of the degree of agreement even when

conservative estimates are sought. Unlike individual level data, the collection of cultural data required purposive sampling to maximize cultural knowledge, thus convenience sampling was acceptable (Handwerker and Wozniak 1997). Key informants were individuals who I had built relationships with in ULH and their acquaintances who they believed to have good knowledge of African American life.

Key informants used a structured survey to rate all items that were previously generated with the free-listing exercise (see Appendix B). The survey asked key informants to rate the degree to which items or phrases identified in the first stage were important and common in ULH (not important, somehow important, very important or not common, somehow common, very common).

3.4 Analytic Methods

Ethnography: Field notes and analysis of field notes are central to ethnographic research (Emerson, Fretz, and Shaw 2011). To remember information and conversations, I carried a pocket size fieldwork notebook where jottings were entered regularly. Sometimes, I took a break after informative conversations or observations to talk about the information on my recording device. Voice recordings were transcribed and jottings developed into field notes. Since ethnography is an iterative process, I immediately analyzed field notes to generate questions that were important to explore in subsequent observations and conversational interviews.

Although this is grounded in consistent theoretical foundations, data generated to answer research questions were coded and analyzed using an integrated approach to coding – adopting both deductive and inductive techniques. Deductively, a preliminary organizing

framework for the codes was created based on theory, extant literature and the research questions (see appendix A). This was achieved by locating portions of the field notes that represented a priori constructs, themes, or ideas. Inductively, emergent categories were identified from the data (Miles and Huberman 1994).

Constant comparative coding analysis was implemented by comparing new texts segments to those that had been previously assigned the same category, and then deciding whether they were sufficiently similar to be integrated, or be assigned different codes (Glaser and Strauss 1967). The process of applying or refining dimensions of existing constructs and identifying new categories is useful in that it prevents the researcher from imposing predetermined outcomes to the study, while at the same time benefitting from theoretical insights in that particular area of inquiry (Bradley, Curry, and Devers 2007). I used NVivo software to assist with managing, coding and organizing field notes

Cultural Consensus Analysis: I entered the survey data into Stata and ran basic descriptive statistics of my sample as shown on Table 3.1. Demographically, the sample of key informants was diverse. A little over one half were men. Ages ranged from 22 to 82 years, with a mean of 49. High school education was the highest level of educational attainment for a third of the key informants. Two in ten had a college degree or higher. The majority of key informants had lived in ULH for more than a decade, and as such, considered themselves to be familiar with African American life in the neighborhood. Seven in ten considered themselves to be very religious, and eight in ten had either received or knew someone who had received mental health services.

Table 3.1: Characteristics of key informants who rated items in CCA (N=40)		
	%	**N**
Men	55	22
Age in years, $\bar{x}$ (sd)	48.9 (18.1)	40
Education		
No High School	28.1	11
High School	33.3	13
Some college	17.9	7
College degree +	20.5	8
Years in ULH, $\bar{x}$ (sd)	20.6 (8.2)	40
Religiosity		
Not Religious	10	4
Somewhat Religious	20	8
Very Religious	70	28
Has received or knows someone who received mental health services	82.5	33

To assess whether there is consensus in the categories of items rated, I transposed the data such that informants were columns and the variables or rated items were rows. This ensured that exploratory factor analysis was performed using individuals as variables. As recommended, the iterated principal factor algorithm, without rotation, was performed to maximize the variance accounted for by the first factor (Weller 2007). Factor analysis for each of the components (stressors, stress responses and resources, and depression) was performed separately. The consistency of responses was evaluated from the factor analysis by assessing the ratio of the first and second eigenvalues. The eigenvalue for each factor or an underlying construct is the amount of variance in the data accounted for by that factor. A large eigenvalue means the factor represents some common trait in the variables, which in CCA, it would be individuals. If the first eigenvalue is three times

larger than the second, convention dictates that there is a unidimensional solution with a single response pattern regardless of some degree of individual variation in the responses (Weller 2007).

The presence of a unidimensional solution or single factor represents consensus – the presence of a shared model of stressors, stress responses, and depression. Usually, factor loadings indicate how the underlying construct is associated with the variable on which the factor analysis is performed. In CCA, factor loadings indicate the correlation between the shared construct and the individuals on which the factor analysis is performed (Weller, 2007). Factor loadings are used to weight the responses of each informant in the survey and are aggregated to determine the most significant items or components of the shared model of stressors, responses and depression (Romney, Weller, and Batchelder 1986).

3.5 Ethical Considerations

This dissertation research was approved by the University of Minnesota Institutional Review Board (IRB). Informed consent (see Appendix B) was obtained from key informants. Caution was taken to ensure that participants, especially key informants were comfortable and safe, and could choose to terminate their participation at any time. Pseudonyms are used in the field notes and in writing of the findings. Although this work has no interventional component, when requested, I provided some participants with publicly available information to resources and services.

3.6 Positionality

One of the most provocative developments in ethnography in recent years is the rise of reflexivity (Venkatesh 2013). By its very nature, ethnography provides the opportunity for researchers to reflect on their own perceptions of the phenomenon under investigation, and their relationships to the field sites and research participants. Young (2013) states that the "visibility that researchers experience is a unique and particular quality of the craft of ethnography."(p.51). Morrow and Smith (2000) argue that reflexivity makes the qualitative research process more rigorous, and enables the researcher to record their reactions, expectations, assumptions and biases as the research progresses. Reflexivity highlights relevant assumptions and limitations to the data, and ultimately increases credibility of the ethnographic inquiry (Morrow and Smith 2000; Venkatesh 2013; Young 2013)**.**

Throughout this ethnography, I reflected on my position in the field. My socio-demographic characteristics (college-educated, female, foreign-born), racial identity (Black), and relationships with individuals in ULH have implications for the kind of data collected, the interpretation, and the claims that I make. I was referred to as Black Barbie. When I asked what that meant, Tom, a key contact who I shadowed in ULH explained that I was "like a Barbie, in Ken and Barbie, only you're Black." Some residents of ULH perceived my life and experiences to be better because I was a foreign-born Black person. One Black woman elucidated that I had no baggage. That is, some of the discrediting stereotypes often applied to African Americans were not applied to me, at least not as frequently. Once some residents found out that I was born in Cameroon, they thought that I was smart and privileged to have travelled to the United States. Others felt sorry for me

because I had possibly endured war and famine. Yet, others believed that I was part of a global Black community, as were they, and dealt with the same struggles against racism and other forms of oppression. Most of the people with whom I maintained relationships, and whose experiences invariably contributed to this work were those who felt that we had things in common or had more similarities than differences with respect to our experiences of race in the U.S. Another category of people whose experiences are reflected are persons who perceived that I had some status and power, had more access than they did to certain resources and privileges, felt obliged to engage with me, or anticipated that they might enjoy some benefits from being acquainted with me.

My relationships with key contacts familiar with street life gave me access to some circles that I would otherwise be unable to access. But being foreign-born with a thick accent, people were curious to talk to me, ask me questions about my life, and listen to my story. I took advantage of these attributes, as well as people's natural curiosity to enter into potentially violent spaces and make acquaintances. For example, as they tried to figure out where I was from or why I was asking questions about a fight when most others knew better than to get involved, I had some extra time to assess how safe I was, if I should continue to foster a conversation, or immediately negotiate an exit strategy. In general, key contacts as well as residents with whom I casually interacted felt that I was deserving of protection; maybe because of perceptions that I was naïve and unfamiliar with navigating neighborhoods such as ULH. People warned me about my safety and asked me not to go to locations they themselves went to regularly. I was often reminded that ULH was different from neighborhoods I had lived in. These individuals - persons

who were somewhat sympathetic towards “the African” or “Black Barbie” - were those more likely to engage with me, and their perspective greatly informed this work.

I entered the field without fear, assuming I would be safe accessing residents’ exposure to objective stressors. However, my first observation of gun violence which occurred after I had been in the field for about 5 months left me paranoid for several weeks. Shots were fired during a fight, and I had to deal with a real possibility that I could get shot. I hesitated going to certain locations including the area where the gun shots occurred, and was reluctant to go to or engage with persons in certain areas in ULH. This experience limited the nature of data that was collected. In addition, I reflected on the privileges that I enjoyed such as the ability to leave ULH when I wanted to. I began thinking more about responses to stressors such as gun violence by residents who lacked the resources to move to safer neighborhoods. I became more aware that I was indeed an outsider, and did not understand what it meant to live in ULH everyday with the fear of being shot and with no hopes of moving. As a result, the work at that moment, focused more specifically on exploring cognitive and behavioral responses to stressors than simply on stress resources.

Finally, my status as a researcher with advanced degrees shaped the research process. As expected, some residents felt obligated to participate in conversational interviews or to engage with me because of the asymmetric nature of the relationship. However, it became evident that the power that I had as a researcher was not only apparent when potential participants felt that they needed to respond to my questions and accommodate my sometimes annoying and overbearing presence in their spaces. Some participants also perceived and expected that I should be able to do something in return with the

information, to make decisions, provide resources or even “pull some strings” that may change their circumstances. When asked to use my influence in helping one of my key contacts to be released from jail, I had a blank look on my face and went on to explain that it was not something I was able do. For a while, it became harder for his friends to continue to share information about their lives that was relevant to my work. One of his friends said that all I did was “use shit we tell you but don’t do shit to help the people who help you with your paper.” This made me to reflect on the importance of transparency and clarification about what we can provide as researchers, and more importantly, how the expectations that participants have towards us may shape data that we collect.

3.7 Member Checking

Throughout the course of this work, I frequently discussed my observations and field notes with participants who commented on their accuracy and on my interpretations of observations. For example, I had followed Ice to his friend’s workplace. Although every one there seemed calm to me, Ice later on told me that his friends were anxious about me being there. I shared my interpretation of why they seemed calm. I told Ice that I had observed and learned that when Black men are anxious or worried about something, they don’t really talk about it or let others in on their feelings because it would signify weakness. However, he clarified that in most cases, “acting cool” and not showing anxiety had nothing to do with the fear of being perceived as weak. It has more to do with “self-protection”, he said. Ice explained that most Black men he knew, did not want to expose themselves to cross-examination by others. Had one of his friends appeared anxious, Ice argued that I would have “cross-examined everything fucking word or

question that came out of his mouth" as would a police officer. These kinds of member checking conversations happened frequently as I gathered and analyzed the data.

After the findings were written, I discussed them with five key informants. I asked for general comments about the findings and for specific remarks about the accuracy of themes that emerged around stressors, resources, stress responses, mental health problems and expressions of depression. These participants had positive comments about the work, and felt that their stories were told accurately. However, their positive feedback might be due to the fact that these persons shaped the nature and interpretation of data constantly as member checking was part of the data collection process. In addition, the power imbalance in my relationship with participants might have obliged some participants to provide positive feedback about my findings.

Chapter 4

CHARACTERIZING THE PLACE OF ABODE

In this chapter, I review the relationship between neighborhood context and health, and use survey data, observations, and conversational interviews to describe Upper Lake Heights (ULH). I describe its racial composition, socioeconomic and health characteristics, and resources that might be relevant to mental health. Neighborhood context and characteristics are important determinants of health (Kawachi and Berkman 2003). The physical, social and economic features of a neighborhood affect the health of its residents. Neighborhoods can be understood through features including socio-demographic composition (for example race and class), crime rates, social relationships, and structural and institutional resources (Sampson, Morenoff, and Gannon-Rowley 2002). Whether differentiated by race or socio-economic status (SES), neighborhood composition increases or decreases neighborhood desirability to particular groups of people, leading to important social implications. For example, the presence of structural and institutional resources: better schools, parks, recreational facilities, community programs and social activities may attract certain groups of people. At the same time, the increasing presence of one group may cause another group to leave (Galster 2001), changing the aggregate income level and racial composition of a neighborhood.

Physical characteristics such as air pollution, poor quality water, the presence of hazardous substances, and exposure to lead or mold can endanger health (Diez Roux 2001; Macintyre and Ellaway 2003). Characteristics of social relationships among neighbors and opportunities for economic development can also affect the health of

residents. Persons residing in neighborhoods where there is mutual trust and close positive relationships collaborate to achieve and preserve clean and safe public spaces, and to maintain informal social control that limits the flourishing of crime and unhealthy behaviors (such as drug use) that negatively affect health (Aneshensel and Sucoff 1996; Sampson, Morenoff, and Gannon-Rowley 2002). The availability of services such as good transportation systems, high quality schools, health and employment services also influence health directly by affecting resident quality of life (Osypuk and Acevedo-Garcia 2010; Rosenbaum 1995; Williams and Collins 2001a). As a result, persons who live in poor neighborhoods with limited social and economic opportunities are likely to have poor health.

Unfortunately, not everyone has the opportunity to live in neighborhoods that have significant social and economic resources. Racial residential segregation- the process by which people are separated into different neighborhoods based on their race- is a mechanism of institutional racism that limits interactions between Whites and members of racial minority groups (Williams and Collins 2001a). In the United States (U.S.), Whites and relatively privileged groups move to suburban neighborhoods, leaving racial minority populations in urban areas with the highest concentration of poverty (Lee et al. 2008; Logan, Stults, and Farley 2004; Massey 1990). It is common to find communities of Blacks living in urban poverty across cities in the U. S.

Residential segregation and resulting inner city neighborhoods that consist of large Black populations have high rates of unemployment, violent crime, and residential instability that is associated with the absence of community and economic resources, and with low

educational achievement (Adelman 2004; Anderson and Massey 2004; Massey 2001; Quillian and Pager 2001). Because these structural problems create and reinforce socio-economic disadvantage, Williams and Collins (2001) argue that racial residential segregation is the basis for racial disparities in health. Neighborhood segregation fosters health disparities in that while certain populations have disproportionate access to resources, others (especially Blacks in urban areas) have limited resources and are exposed to adverse living conditions.

Poor living conditions and the underlying structural problems constitute negative environmental triggers that may lead to risky health behaviors, elevated stress, reduced social control and social cohesion, and can ultimately increase the risk of mental health problems (Gary, Stark, and LaVeist 2007; Kim 2008; Latkin and Curry 2003; Simning, van Wijngaarden, and Conwell 2012). In contrast, the presence of resources such as better schools, parks and recreational facilities may improve living standards. These resources increase a community's social capital and help to reduce the impact of adverse neighborhood factors on health. Consequently, neighborhoods with social amenities and economic resources have better physical and mental health at the individual level (Galea et al. 2007; Galea et al. 2005; Ross 2000; Wandersman and Nation 1998).

Using the most recent data from the American Community Survey (ACS), a county-based health survey, and direct observations in the field, this chapter provides a brief description of the neighborhoods that are the focus of this study. I collectively refer to this cluster of neighborhoods as the Upper Lake Heights (ULH). ULH is located in the north side of a large Midwestern city. In this chapter, I describe the demographic

composition and present some indicators of disadvantage and objective stressors that characterize ULH. I also provide an overview of the health profile of the population and describe neighborhood social resources that may be relevant to mental health.

4.1 Demographic Composition

Upper Lake Heights has undergone considerable racial transformation over several decades: hosting Jews from Russia and Eastern Europe in the early 1900s; drawing a large population of African Americans after World War II; and home to Asian immigrants in the 1970s. Currently, ULH is disproportionately African American, although several pockets of culturally diverse residents are dispersed across the neighborhood.

In 2010, ULH had an estimated resident population of 27, 428. This represents approximately eight percent of the city's population. In the last decade, the population of ULH has declined. According to five year estimates (2008-2012) from the ACS[1], African Americans/Blacks make up 58.4 percent of ULH compared to only 19.9 percent of the city's population, and to an even smaller 12.6 percent of the total U.S. population (see Table 4.1).

[1] The American Community Survey (ACS) is a nationally representative annual survey that assesses demographic, economic, social and housing characteristics of the US population. Housing units and group quarters facilities are drawn from the Census Bureau's Master Address File (MAF). Sampling rates are assigned independently at the census block level. The ACS samples close to 3 million addresses each year and obtains about two million final interviews. Data is collected using three modes-mail, computer assisted telephone interviews and computer assisted personal interviews. The ACS combines data from multiple years to produce reliable estimates for smaller geographic areas including 5-digit zip codes. The estimates presented here are 5-year estimates. These estimates are averages over the period from January 1, 2008 through December 31, 2012 and are representative of the total population of the 5-digit zip code area for ULH. Monetary values such as annual income for the ACS 5-year estimates are inflation-adjusted to the final year of the period.

Table 4.1: Selected characteristics of Upper Lake Heights (ULH), the city, the state and the United States- Five Year (2008-2012) estimates from the American Community Survey (ACS)

	ULH	City	State	United States
Black (%)	58.4	19.9	5.1	12.6
White (%)	17.3	68.3	86.0	74.2
Asian (%)	17.9	6.3	4.7	5.6
American Indian and Alaskan Native (%)	3.5	3.0	1.9	1.6
Native Hawaiian and Other Pacific Islander (%)	0.2	0.1	0.1	0.4
Some other race (%)	5.6	3.3	1.6	5.3
Hispanic of any race (%)	8.3	9.9	4.7	16.4
Percent foreign-born (%)	12.8	14.6	7.2	12.9
Female (%)	53.6	48.9	50.3	50.8
Median age	26.1	31.7	37.4	37.2
Female-headed households (%)	33.5	11.9	9.4	12.9
Average household size	3.1	2.2	2.4	2.6
Married males, age 15+ (%)	28.1	33.4	54.1	51.1
Married females, age 15+ (%)	23.0	32.6	52.0	47.4
Bachelor's degree+, adults 25+ (%)	16.8	45.5	32.2	28.5
Living in poverty (%)	40.0	22.5	11.2	14.9
Living in poverty, with children ≤ 18 years old (%)	44.2	24.8	11.9	17.2
Living in poverty, 16+, worked full time year round (%)	7.3	2.9	1.8	2.8
Living in poverty, Black (%)	68.1	45.5	35.1	26.5
Living in poverty, White (%)	25.7	14.8	8.7	12.1
Past 12 months food stamp/SNAP benefit (%)	39.3	13.7	7.4	11.4
In labor force yet unemployed, age 16+ (%)	23.0	9.5	7.0	9.3
Mean household income	$41,440	$69,487	$76,372	$73,034
Percent with disability	14.8	10.0	10.2	12.0
No health insurance (%)	15.5	12.9	8.7	14.9

Only 17.3 percent of the ULH population is White, and 17.9 percent identify as Asian. Foreign born persons make up about 12.8 percent of ULH. The majority of this population was born in Asia (52.5%) and in Latin America (28.8%). ULH has a large

population of young adults; the median age of ULH residents is 26 years- eleven years younger than the national estimate. The average household size in ULH is 3.1, and majority of family households are female-headed households living in rental units. The proportion of female-headed households in ULH is almost three times that of the city. Compared to the city, state and entire U.S. population, fewer ULH residents age 15 and older are married.

4.2 Indicators of Disadvantage

Here, disadvantage refers to multiple factors that reduce life chances and opportunities for individuals in a community, and that ultimately increase risk for poor mental and physical health. As shown on Table 4.1, data from the ACS about poverty, unemployment and educational attainment of residents show that ULH is more disadvantaged than the rest of the city (see Table 4.1). For example, while the poverty rate for the city is 22.5 percent, the proportion of ULH residents living below the federal poverty line is almost twice as high (40%). This is probably associated with high unemployment rates (23%) in ULH compared to entire the city (9.5%). Poverty in ULH is widespread even among the employed. Up to 7.3 percent of persons aged 16 and older who worked full-time year-round in the past 12 months are still living in poverty.

In addition, 44.2 percent of households with children under the age of 18 are living in poverty in ULH compared to only 24.8 percent of similar households in the entire city and 11.9 percent across the state. Although poverty rates are high among all race and ethnic groups in ULH, there are considerable disparities in poverty rates between Whites (25.7%) and African Americans (68.1%). Household incomes are much lower in ULH

and consequently, a greater proportion of ULH residents benefit from Supplemental Nutrition Assistance Program (SNAP).

Crime is also a significant problem in ULH. There is increased police presence, and most houses have metal bars on the doors and windows. A few houses, some of which are currently inhabited, had visible bullet holes on their walls. I met several residents who had been victims of robbery and aggravated assault, and others who had lost relatives through homicides. As I came to learn, it was not uncommon to hear gunshots during early evenings and nights in some of the neighborhoods in ULH. Indeed, in the summer months, violent crime rates rose significantly- a trend expected by many residents. In June and July of 2014, there were seven homicides in the city, six of which occurred in the cluster of neighborhoods that constitute ULH.

Similar to neighborhoods in other U.S. cities with concentrated urban poverty, ULH is visibly disadvantaged. Several deteriorating and uninhabitable houses are dispersed across the neighborhoods. Blocks with decent and nice looking houses are interspersed among more run-down dilapidated housing units, some of which are vacant and foreclosed. Fraying blue tarps can be seen covering parts of the roofs of some of the houses that were hit by tornados several years go. While there are buildings with astonishing paintings and murals in certain parts of the neighborhood, several of the side streets are littered with garbage including used needles and syringes.

In the winter months, the streets of ULH are considerably littered, but the garbage is quickly covered in snow. Often, it takes several days before some of the major streets that run across ULH are plowed. As a result, transportation becomes difficult and commute

time to the downtown area is much longer than in the warmer months. Numerous side streets in ULH are unplowed and most sidewalks remain covered with snow throughout the winter. Finding a walking path to bus stops is difficult. People are often waiting in the streets to get on the bus because bus stops are icy or covered with snow and are inaccessible. In addition, transportation options to business districts are limited, leaving residents isolated from (potential) employers.

The housing and living conditions of most African Americans in ULH vary from poor to horrible. People often talked about difficulties in finding affordable decent housing-housing that has reasonable heating and plumbing, a satisfactory appearance, and adequate lighting and roofing. Several of the detached one and two story homes have been converted to multiple units that house more than two families. Most of the residents with who I interacted often expressed frustration about foreclosed dilapidated houses being frequently bought by individuals or corporations who proceeded to "slap some paint on" and then rented to tenants who could not afford better housing. These units are described by some residents as having poor heating and plumbing, leaking roofs, and/or mold infestation. It is not uncommon to see "for rent" signs on the same houses every few months because of housing instability and residential mobility.

Several Black families who I encountered in ULH could be described as struggling members of the lower working class. Most struggled to find sufficient work to remain employed, and sometimes, this meant involvement in several highly precarious employment situations. The case of Mike, an African American middle-aged man, is illustrative. Mike lives with two other adults and four children in a two bedroom duplex.

He does not own a car and works two jobs as a commercial cleaner and as a floater. As a floater, he does not always know where he would be sent to for work if he is needed. His work location is typically assigned on morning of the work day, leaving him with no steady placements. It took him several months to find employment, and the jobs require him to be available on short notice and to travel to different locations in the city. Although the other two adults with who Mike lives also work outside of ULH, they cannot afford to rent a larger house in ULH or similar housing in the relatively less disadvantaged neighborhoods where they often go to for work. Mike, like several African Americans and their children are trapped in substandard living and housing conditions in ULH. This cycle of poverty, unemployment, and precarious working conditions engenders crime and violence, and naturally increases vulnerability to physical and mental health problems.

4.3 Health Profile

In casual conversations, residents of ULH often talk about their health in positive terms. A first glance at Ralph, an older male limping heavily as he moved towards the bus, showed bruises on his face, a bleeding wound on his left arm, and a jacket shredded and covered with mud and blood. Despite his appearance, Ralph's response when asked about his apparently poor physical condition is that he is feeling okay. He would later disclose that he had been involved in a physical struggle and had gotten stabbed by two teenagers who robbed him. As is frequently the case with other people I met, a series of follow- up questions are likely to prompt less positive assessments of health. For example, after initially stating that her health was fine, a young mother proceeded with a list symptoms that she was: "dealing with okay", because she considered herself to be "strong". These

symptoms were shared not to acknowledge poor health, but as evidence of doing well, in spite of symptoms that are attributable to less than optimal health.

The health status of residents in ULH can also be approximated using estimates obtained from a 2010 county- based survey. However, a significant limitation in using data from the county survey is that too few African Americans and persons who belong to other race and ethnic minority groups are represented in the survey. However, the survey report provides some information about the health profile of residents in ULH (Table 4.2).

When asked about health, 14.5 percent of ULH residents responded that for 14 or more days in the past month, their physical health has not been good because of a physical illness or an injury. This is twice the proportion of persons reporting the same number of poor physical health days in the city, and more than three times greater in one of the affluent neighborhoods in the city. Similarly, the proportion of persons with 14 or more mental health days in the past months, and who rate their overall health to be fair or poor (as opposed to excellent, very good or good) are considerably higher in ULH than in an affluent neighborhood and in the entire city. These data are not surprising since ULH is among the most disadvantaged neighborhoods in the city.

To help improve the health of residents, ULH is home to one of the largest federally qualified health care centers in the city. The center provides medical, dental, and mental health services on a sliding scale based on family size and income. It serves an important role of brokering community resources - connecting residents with food shelves, legal assistance, adult education, language assistance, health insurance, crime victim support, and shelters for homeless persons and victims of domestic abuse in the city.

Table 4.2: Selected health and social characteristics of residents of Upper Lake Heights, an affluent neighborhood, and the city using estimates from a 2010 county-wide health survey

	ULH	Affluent neighborhood	City
Poor general self-assessed health (%)	3.5	1.0	2.0
14 or more days of poor physical health because of physical illness or an injury - past 30 days (%)	14.5	4.4	7.8
14 or more mental health days - past 30 days (%)	17.9	8.4	10.7
14 or more days in the past 30 days when poor physical or mental health prevented residents from doing usual activities such as work and recreation (%)	13.4	3.8	6.7
Never involved in school community or neighborhood activities (%)	29.1	20.4	24.8
Weekly attendance in place of worship (%)	28.0	23.3	24.5

4.4 Social Resources

Amidst crime, unemployment, isolation, and residential instability, relentless efforts of religious and educational institutions and community organizations are geared towards improving the lives of people in ULH. While the county-wide survey[2] suggests that compared to other neighborhoods in the city, ULH has the highest proportion of residents who are never involved in school, community or neighborhood activities, ULH also has the greatest proportion of residents who go to a church, temple, synagogue, mosque, or other place for worship on a weekly basis. There are 27 registered churches in an area

[2] The county survey is a self-administered mail-in household survey of the health and well-being of residents. Households were selected at random from a sample frame of addresses from the US Postal Service's Delivery Sequence File. There were six primary geographic sampling areas, and each household address was geocoded into a sampling area. Smaller geographic sampling areas were oversampled to increase representation of African Americans, Latinos/Hispanics, Asian and African immigrants in the survey. Once a household received the survey, the adult with the next birthday completed the adult survey. The survey was conducted between June and September of 2010. The total adult sample was 7,071 and the response rate for the survey was 23.3%.

estimated to cover 4.1 square miles. The churches vary in size. Some are housed in small buildings with cracks on the walls, paint chips falling off, and that have torn doorsteps with the concrete cracked or broken off. Others are large structures of different shapes with huge parking lots and additional buildings on the side that house extensions of the church used for community groups and shelters. Yet, other churches seem to operate from the houses of individuals and have small, almost invisible signs in the yard or sometimes on the window.

The role of church as one of ULH's strongest resource was demonstrated on several occasions. For example, when a tragedy befell a non-religious family leading to the death of five children under the age of 12, the church played a significant role in providing support to family and community members. The church organized a vigil, spearheaded fund-raising efforts, collected in-kind donations, took charge of the funeral, and coordinated sign-up sheets for hospital and home visits of surviving family members. On cold winter nights, several churches become emergency shelters for homeless residents, serving hot food and providing warm clothing. In community meetings, people would often state their church affiliation before proceeding to make their contributions to the issues discussed. Church membership was an implicit credential for participation in some community events, and the opinions of persons with strong affiliations to the largest churches commanded more respect during such events.

In addition to churches, ULH is home to several parks, recreations centers, and public libraries. Parks and recreation centers provide spaces for people of all ages to engage in various activities including sports, cooking, movie nights, and arts. Most of these

activities are free for ULH residents. The conditions of parks and recreation centers in this cluster of neighborhoods range from decent to deteriorating. Whites who live in ULH disproportionately partake in activities at the decent-looking facilities while racial minority populations can be seen in recreation centers where the overhead lights are hanging dangerously from their fixtures, and with several cracks and crevices visible on the walls and in the floors. The libraries are by far the best looking public buildings in ULH. In addition to reading spaces and computer labs, libraries offer a variety of services including tutoring, employment skills, resume assistance, tax preparation, English language learning, naturalization test preparation and homework help. In most of the libraries, service providers are overwhelmingly White, and persons belonging to racial minority groups are more likely to be service recipients. Nevertheless, in the relatively Blacker and more disadvantaged parts of ULH, there was a more racially proportionate distribution of roles in two libraries where Black tutors were helping Black, White, Asian and Latino persons.

4.5 Neighborhood Stressors and Mental Health

The neighborhood characteristics described are important for understanding how social factors affect vulnerability to mental health problems. In their classic article, Wandersman and Nation (1998) propose the structural characteristics model that defines a clear association between poor mental health of residents of a neighborhood and structural indicators of disadvantage such as high rates of unemployment and poverty within the same neighborhood. They also propose a similar model- the neighborhood disorder model that hypothesizes that both physical (street litter, condemned buildings)

and social (street crime, gangs, feeling unsafe) signs of neighborhood deterioration are associated with mental health problems (Wandersman and Nation 1998).

Several well-designed studies provide evidence for the models proposed by Wandersman and Nation (1998). For example, Ross (2000) found that among adults in Illinois, residence in poor neighborhoods with a high proportion of female headed or mother-only households was associated with greater depressive symptoms. Using a cross-sectional New York City study, Galea and colleagues (2005) also demonstrated that residents of neighborhoods with poor quality built environment had greater likelihood of past six month and lifetime depression compared to their peers in more affluent neighborhoods after adjusting for individual characteristics. Other studies found similar results – lower SES neighborhoods associated with higher rates of depression, affluent neighborhoods protective against worsening symptoms (Beard et al. 2009), neighborhood unemployment rates associated with greater depressive symptoms (Wight et al. 2013), community disorder predicted psychological distress (Cutrona et al. 2000), and perceived neighborhood crime and drug problems associated with psychological distress and lifetime psychiatric disorder (Booth, Ayers, and Marsiglia 2012; Simning, van Wijngaarden, and Conwell 2012).

Sampson et al. (1997) framed the concept of collective efficacy to represent the combination of neighborhood social cohesion and informal social control, which when present, increase mutual trust among neighbors. Collective efficacy also increases the willingness of neighbors to intervene in a common cause. Collective efficacy is lower in disadvantaged neighborhoods and is inversely proportional to crime rates (Kawachi,

Kennedy, and Wilkinson 1999; Sampson, Raudenbush, and Earls 1997). Neighborhoods like ULH with objective features that can be described as dangerous have decreased collective efficacy due to increased fear, the sense of powerlessness and mistrust among residents, and difficulty in forming supportive relationships (Ahern and Galea 2011; Ross and Mirowsky 2009; Stockdale et al. 2007). These factors are associated with psychological distress and poor mental health (Booth, Ayers, and Marsiglia 2012; Chou 2012; Dupere, Leventhal, and Vitaro 2012; Rios, Aiken, and Zautra 2012).

Transportation problems such as those common in ULH are associated with poor mental health mostly because they act as barriers to mental health services among those who need care (Owens et al. 2002; Taylor 2001; Ward-Colasante and ohn Farmer 1993). A UK-based study found that compared to shorter commutes, commute to work using public transit and longer than 60 minutes (from door to door) is associated with higher rates of psychological distress in the general population(Feng and Boyle 2014). ULH residents experience long winter commutes due to unplowed roads. In addition, there is uncertainty about the exact time a bus would arrive. These factors together with increased likelihood of precarious employment and employment in sectors that require frequent transportation to different job sites may make transportation stressful. Consistent with the stress process, transportation difficulties are daily hassles with the potential to increase risk of mental health problems (Pillow, Zautra, and Sandler 1996; Wheaton 1999).

Neighborhood characteristics that increase risk of and vulnerability to poor mental health such as poverty, mother-only households, crime, dilapidated housing, and transportation hassles are prevalent in ULH. Consistent with previous research, these objective

neighborhood factors that characterize ULH are considered stressors by researches - experiential situations, chronic strains, or conditions that produce stress, and should lead to poor mental health among ULH residents. I argue that for these conditions or experiences to cause poor mental health among residents, they must be perceived and appraised as stressful. One of the central claims of this dissertation is that phenomena are only considered stressful within the context or culture of their existence. Conditions that may be stressful among Blacks in ULH may not be stressful when encountered in another community, and vice versa. Although perceived neighborhood characteristics may emerge from objective conditions, neighborhood perceptions can also be a combination of objective features and psychological resources or completely divergent from objective characteristics (Bowling and Stafford 2007; Clark et al. 2009; Wen, Hawkley, and Cacioppo 2006). The definition, perception and appraisal of stressors are contingent on the cultural context within which stressors occur. Culture therefore provides a way of assessing whether certain situations or experiences are fundamentally stressful and threatening to mental health. In the next chapter, I describe culturally salient sources of stress and identify factors, conditions and experiences that are considered stressors based on shared understandings and meanings of the everyday lives of Blacks in ULH.

Chapter 5

CULTURALLY SALIENT STRESSORS

One of the main objectives of this work is to identify sources of stress among African Americans living in Upper Lake Heights (ULH). This chapter addresses the first research question to describe culturally salient sources and characteristics of stress. I define culturally salient stressors as phenomena appraised by ULH residents to be stressful through frames, repertoires, and narratives. I explore the context within which stress is experienced and how events become stressful. In ULH, circumstances and events come to be perceived as stressful based on community expectations and beliefs about life. Such events are culturally salient stressors because of the shared notions about how they impose challenges to everyday life.

Salient Sources of Stress

Objective indicators of social disadvantage prevalent in ULH are considered stressors by researchers. Yet, there are contingent processes by which any situation, condition, event, or experience comes to be constructed as a stressor within a population. In ULH, one of these processes is social comparison. An objective source of chronic strain such as long term unemployment will only become a salient stressor in ULH if other African Americans within one's networks are employed, or if one perceives himself or herself to be doing worse in relation to unemployment than others s(he) knows and interacts with regularly.

Ray's view of his circumstances provides an example of how circumstances can be thought of as stressors using social comparison. Ray was a middle aged man who had

never had a regular job. He occasionally shoveled driveways in the winter and mowed lawns in the summer. None of his friends had any “legitimate gigs” or sources of income, and in comparison, Ray believed that he was doing well. He never thought of himself as unemployed or alluded to potential stress or worry from his lack of a regular job. He would later reference the fact his adviser in college did not help him to stay in college and to graduate, as was done for the White students on his football team. However, he evaluated his outcomes including employment status in comparison to other Black friends in ULH, not to the friends he had when he was in college.

Josh’s experience was different from Ray’s but the outcome was similar. Josh was a young man with a four year old son in whose life he was involved. Although Josh too had been unemployed for several years, unemployment was not a salient stressor for him because his father was never employed. People I interacted with evaluated their experiences in comparison to others in similar circumstances or to similar others in contexts that are considered less flourishing than theirs, such as family and friends living in objectively more disadvantaged cities.

Expectations of social mobility also influence whether residents of ULH perceive events as salient sources of stress. Ray, Josh, Tom, and Mary were some of the residents I interacted with frequently who felt that their current social positions where the highest they could attain because they could not overcome structural barriers that other Blacks commonly face. Mary, for example, worked as a part time waitress at a restaurant. She applied for the job because “there were no White women applying to work here.” When

asked if she was looking for better opportunities, she responded that: “there’s no need to want the things you can’t get. It’ll only hurt you.”

Tom had similar expectations about the social status of Blacks compared to Whites. Tom had spent eight months in a juvenile prison for possession of marijuana and for shoplifting. He was 17 at the time. “I was young and stupid”, he said. “I wanted to be popular in school.” According to Tom, his parents expected that he would be involved with the justice system at some point. Both of Tom’s parents worked long days to take care of him and his three siblings. Even though things were very difficult for his family financially, his mom would often ask them not to worry about money, and that their only job was to work hard at school. But Tom explained that working hard at school did not give him the summer jobs that his more privileged friends had. Some of them worked for their parents’ businesses. Others had family, friends, and relatives who would make sure that they had good paying summer jobs or sent them to affluent summer camps. Tom was unable to get the latest jeans or sneakers that others had. His parents would often tell them that they could not have the same things that the White kids had, and that they had to work twice as hard in school to have a shot at the lifestyle and opportunities that Whites had. Tom did okay at school and stayed out of trouble until he turned 17. “I wanted in. I started moving grass”, he said. He was amazed by how much money he could make.

In ULH, African Americans expected that life would be more difficult for them compared to Whites, and that upward social mobility was hard. African Americans understood that they will have more severe consequences for their offenses, and that pervasive

institutional arrangements limited the life chances of young Black men including Tom and his friends. Unfortunately, shortly after Tom started selling marijuana, he was arrested. “We got busted. Doppy White kid got us caught. But they only gave him a week in juvie”, Tom said. However, Tom thought that he was lucky because two of his friends with whom he sold marijuana were tried as adults and were in jail much longer. Tom went to jail for a year based on this offense.

As demonstrated by the experiences of Mary and Tom, expectations around social mobility and life chances likely shaped outcomes and meanings of outcomes among Black residents of ULH. They expected limited opportunities. Although they desired social mobility through permanent employment, their expectations of upward mobility was lowered by structural barriers that they had become familiar with through their personal experiences or from conversations with family members and friends. The knowledge that their life chances were not the same as those of Whites, and that certain statuses may not be attainable might determine whether the lack of attainment of some statuses such as permanent employment would be a stressor significant enough to interfere with what they perceived as normal functioning. The context within which people live, reference categories for social comparison, and beliefs and expectations about life determined what constituted salient stressors. Salient sources of stress in ULH were racism, gun violence, police harassment and role strain.

Racism

Researchers argue that racial discrimination is considered one of the most chronic sources of stress among African Americans (Feagin 1991; Williams and Collins 2001b; Williams

and Mohammed 2009). Residents of ULH often expected and experienced discrimination based on race. One resident said: “We been in this long, we know shit is gonna happen. Then shit happens and we deal.” Even though racism was common and anticipated, experiences of racial discrimination were not easy to deal with. For instance, Tom explained during one of our conversations that he had responded to ads from people seeking roommates but often got turned down when they saw that he was Black. “It’s happened with jobs too, and you just know you’re not gonna get hired because of it”, he said. BobbyJo, a middle aged woman who was very concerned about her son’s experiences in school described how her son had gotten suspended many times for things that White students got away with. Her friend, an older Black male commented that: “This dumb racist shit is fucking messed up and stuff. It kills!” He continued: “I say worse than when they was lynching us, cos it was quick back then.”

Such comparisons of how racism operated several decades ago with more covert forms of racism and its effect in present day United States were common. During a conversation with an elderly woman in the lounge of a community library, she talked about how racism was worse in her day than now. “You got a better shot than me, than my sons even”, she said. She encouraged me to make use of the educational opportunities I have today and not pay attention to how people will mistreat me. She added: “They gonna try to screw you over, but don’t think about them racists.”

Several other residents talked about experiences of racism as a significant source of stress for African Americans. I was riding the bus one Wednesday morning when Terrell asked me about the book I was reading. It was “*The Souls of Black Folk*” by W.E.B Dubois.

Terrell was wearing a white t –shirt that was worn-out around the neck. His hair was uncombed and his general appearance was unkempt. He had a plastic bag that contained pieces of clothing, and the assumption could easily be made that he was homeless. When I showed him the front cover of the book, he said that it must be another book about "our sweat and suffering." Reaching closer to me, he whispered: "I hate to say but White people think just cos they don't have slavery no more that things are working for Black folk." As we talked, I learned that Terrell lived in a homeless shelter and worked three jobs. At one of his jobs at a fast food chain restaurant, he did not get a promotion to shift manager because of his criminal record. Yet, his boss had promoted a White colleague with similar criminal record. "Shit ain't working. But we gonna persevere and pray for the day a savior will come get us from this place", he said.

Residents of ULH experienced racism in their interactions with individuals and with larger institutions such as schools and law enforcement. Takesha, a young Black woman who worked two janitorial jobs had gotten notice from her landlord that she needed to move out. Police had come to the rental property twice within one week to question her 14 year old son who as she described, had "punched a fucking lunatic". She explained to me that her son was "a calm and good kid" who had gotten increasingly bullied because of his weight. According to Takesha, her son had snapped and punched one of the bullies who thought "because he's fucking White, he can get away with any fucking shit". After the police left her house the second time, her neighbor, an older White woman, asked her to resolve whatever was going on because she felt uncomfortable having the police come to the building regularly. After explaining nicely that things were being handled, Takesha's neighbor responded: "Whatever. I know to expect this when I live with

niggers." Takesha, still very upset about the racial slur, stated how she reacted to her neighbor's comment: "I said fuck that shit! I fucking lost my cool and slapped her in her motherfucking face." Her neighbor called the police and pressed charges against Takesha. The police did not take Takesha's side of the story under consideration. Her landlord also gave her notice to move out of the unit.

Beliefs, perceptions, attitudes, and institutional arrangements that discredit and oppress an individual because of his or her race are stressful. As a group, residents of ULH encounter these forms of oppression regularly making racism a salient stressor.

Gun violence

Exposure to, and witnessing violence were significant sources of stress to residents in ULH. Residents and persons residing in the rest of the city perceived ULH as unsafe. People in ULH worried about their safety and mine because of the high incidence of violent crimes. However, they had two different views on the likelihood of victimization. Some residents believed that gun violence was random - that violent crimes were generally senseless and perpetuated by people who took out their frustration on others who were at the wrong place at the wrong time. Other residents felt that it was nearly impossible to be a victim of gun violence if neither the victim nor a member of their close networks was involved with a gang. In ULH, most people believed that violent crime was associated with gangs fighting and taking it out on each other or on innocent friends and relatives when there was a falling out. Although there were disagreements about who could become a victim of gun violence, there was consensus that the prevalence of gun

violence within this cluster of neighborhoods was much higher than in any other part of the city.

One afternoon in the spring, I was at a hair salon with several women when we heard a series of gun shots in rapid succession. “That time of the year!” remarked one woman who was getting her hair done, and who had her two young daughters with her. The older daughter ran and stood next to her mother while her younger sister put her hands over her ears to shield the noise from the gunshots. Ellen, the owner of the saloon, explained to me that spring was the season for gang turf wars in ULH and it was common to hear gun shots. The woman with two daughters talked about how she heard gun shots almost every summer day since she moved to ULH over four years ago. As she checked on both of her daughters, she remarked that winter was her favorite season because the gun shots reduced significantly. Ellen added that in the summer, one had to be able to figure out if it was fireworks or gun shots. If gun shots, one had to then determine whether people were “shooting in the air” to make a statement of sorts, or if someone had actually been shot. When I asked whether the police were called, another female customer responded that there were probably thousands of 911 calls every week for service in the area and residents needed to trust the discretion of the police about when to intervene.

The prevalence of gun violence did not make it less stressful to deal with. Although shootings and homicides were common, these were still sources of significant stress. Residents constantly worried about their safety but most of them could not afford to move out of ULH. When I told a young woman that I was doing research to identify specific things or events in ULH that cause stress among African Americans living in the neighborhood, her response was that: “You’re kidding, right? We are living in a war

zone!" Her stress was a result of being "spooked by the guns, shootings, robbery, rape and all the violent shit going on." She, like several residents, did not feel safe at home or out in the community.

Some young Black men who spent considerable amount of time on the streets were themselves stressed by violence and shootings. After several months of spending time together, one of my key contacts revealed that he carried a gun to protect himself because like everyone else, he was often worried about his safety. "I've been robbed too many times", he said. "I got shot three times just trying to go work, and almost lost my life. To live in one of the most dangerous locations over here in [ULH] working nights, dealing with people up to no good, is it really that bad trying to protect myself from being shot again?", he asked.

Some individuals who I encountered in ULH blamed the violence on the "bad behaviors" of young Black men, who might not be considered deserving of protection. One man and his wife who recently lost their son to gun violence believed that police in ULH only protected White residents and assumed that Black men were the perpetrators of violent crime. Several of the persons with whom I interacted expressed concern about the time it took for police to intervene when there was violence in ULH. My own experience substantiated this claim. Late one summer afternoon, I approached a popular ULH park and noticed that there was a fight in the basketball court. There were several Black men and boys in the court. There was cursing and a couple of the men were exchanging punches. A White woman who was riding her bike saw me observing what was going on in the basketball court. Looking concerned about me, she slowed down and said: "Whatever you do, don't go there." Because the fight was escalating, I agreed with her

that things might get out of hand and I began walking away from the park. “I was right” said the woman from her bike. “About what?” I asked. “That you are African. Go home. Not to Africa. I don’t mean to Africa. Your apartment here.” “Don’t try to help this people who shoot each other”, she continued. As she biked away, there was a gunshot at the scene. Fortunately, no one was injured at that time. And as I walked away, I dialed 911 and told the operator about the shot. I was told that the police will be there in less than ten minutes. The fight escalated, and as I observed for considerably longer than ten minutes from a relatively safe distance, the police never arrived. As the fight continued to escalate, there was another gunshot, and I left the area completely while calling 911 for the second time.

Most parents who I encountered were stressed about the safety and future of their children. I spent some time at a popular park and had conversations with a few young adults and parents who were watching a basketball game. As I sat there, three African American boys who were probably teenagers walked by with sagged jeans and baseball hats that were facing sideward. All three boys wore jeans that were ripped similarly on the calf area such that their calf muscles were visible. Their hats were the same, and they all wore red boxers that were only visible because their jeans were sagged. I overheard some of their conversations as they stood by: “Only my third felony...”; “…I’m going directly to prison if I fuck up.”; “You’re only on probation, what the fuck!” One of the mothers who was also watching the game and who sat next to me whispered that the boys were gang members, and that if someone were to search them, they would find guns and knives. She continued that she had a 14 year old son who was currently playing in the game, and no matter how busy she was, she always came out to watch him play. She

watched him “like a hawk” because if she does not, “he’s gonna join a gang, and then he’s gonna get hooked on cracked, and the next thing you know, he’s in jail.” I wondered why being hooked on crack would mean jail time rather than getting treatment. But this woman’s fears and expectations around what could happen to her son tell much about the current social trajectory of Black males. “I’ve seen it happen too many fucking times”, she said.

Police harassment

Historically, law and order structures have instilled fear in Black communities by stop and frisk, racial profiling in crime investigations, and disproportionately arresting, jailing and convicting people of color. These are salient sources of stress in ULH as in other Black communities. There is a lot of emotional labor associated with staying safe on the streets of ULH, especially among Black men. In this case, emotional labor refers to the effort that Black men exert to separate themselves from situations and stereotypes that might get them into trouble. They worry about walking or driving too fast or too slow, and whether they are heading out at a time when a crime has just been committed and the suspect is still at large. Most residents of ULH have friends and family who have had negative experiences with the police, and as such, police interaction is a stressor.

There is the case of a young man who had gotten shot in the leg by a police officer. Some individuals who had witnessed the incident shared the details with me on the bus. The officer had asked the man to stop running or he would get shot. When he kept running, he got shot. It was unclear what he had done although according to witnesses, the police were looking for him, and officers had been tipped off about his location.

The incident led to conversations on the bus about police brutality and harassment in ULH. Some bus riders complained about why the police had to shoot him given the possibility that he might have been unarmed. The bus driver, a White male, said that the man who had been shot was probably armed, and that when asked to stop or be shot, he was taking the chance to get shot when he continued to run. The women on the bus were more vocal than the men, and were quicker to share their thoughts. One woman said the man who ran from the police did so because "he's a man of color. It is enough, dude did something wrong because he be Black." "As Black folk, our instinct is run away from cops. Plain and simple". She continued, emotionally, that: "[in ULH] they're guilty until maybe later on proven innocent. I'll run the fuck away from the cops too". Charlene, another young Black woman on the bus, described how her brother was beaten by the police before being arrested, an experience that continues to cause her feelings of anxiety at the thought of being stopped by the police.

A younger Black man who was following the conversation shared his own experiences with law enforcement. He stated that twice, he had been stopped and frisked by the police who had asked him: "do you want to end up in jail?" - a threat which he described forced him to comply with whatever the officers wanted him to do or say. Frustrated, his voice raised when he said: "It fucking sucks because I wake up and I'm like, am I gonna get stopped? I change my clothes man, looking to wear something that don't make them think I'm suspicious and shit. I'm fucking afraid….paranoid of my commute. Sometimes when some crime happens- that's more fucked up. Y'all don't know how that shit stinks."

Even though police victimization was a salient stressor in ULH, most of the residents felt that increased police presence was needed to combat high crime including homicides. There was also consensus that police could only help to lower crime rates if the police did not profile people based on their race, how they walked, what they wore, or whether they sagged their pants or spat on the sidewalk. After initially thinking that I was an undercover cop, a young ULH man stated that he would not have any problems with a greater police presence if officers "don't harass regular guys minding their own business or smoking pot. Just saying there's dangerous criminals out there and dumb ass police are going after the wrong peeps."

Terrell who I met on the bus described how relations between the police and African Americans are stressful for African Americans, and how this source of stress is significant enough to warrant parental guidance about interaction with the police at an early age. Terrell felt that Blacks in ULH knew that their problems were not caused by other African Americans or because African Americans antagonize officers, as he had heard others say. He went on to share his experience with a White resident in ULH who told him that Blacks get in trouble with the police regularly because: "they don't know how to act in front of cops." Terrell proceeded to explain that he did not know of any Black parent who had not sat their son down and talked with them about how to act around the police, mostly warning them that they would be charged with as many offenses as possible if they were in any way confrontational. Because White young men do not experience the same brutality from the police, Terrell doubted that White parents ever thought about having such conversations with their children. Police harassment in ULH was a salient stressor that led to immediate consequences such as arrests, brutality,

and anxiety. Long term effects would include strained police and community relationships, and social problems that reduce the life chances of African Americans in ULH.

Role strain

Role strain occurs when there is difficulty in performing one or more sets of roles, or fulfilling one or more sets of expectations (Marks 1977). Role strain was a salient stressor especially among women in ULH. Women were expected to fulfill traditional care giving responsibilities towards their partners, children, extended families, and in home-making. Yet, they were also expected to increasingly participate in the labor force and contribute financially to their families. Most Black women that I interacted with in ULH headed their households and had extended family members under their care.

Jaime had three children under the age of six. When I met her, she was exhausted and frustrated with her kids –for asking so many questions, for not wanting to play with Elmo, for not wanting to eat, for needing her attention. Jaime was possibly in her early twenties or younger, had worked all night, and by 11 am, she had not had the opportunity to rest. Her half-brother had been killed in another city that morning. She had just gotten the news, was panic-stricken, and was trying to figure out a way to travel to be with that side of her family. Her mother who usually watched her kids was not feeling well on that day. Jaime was stressed and frustrated, not only because of the events of the day, but because everyone in her family depended on her for "every fucking thing." She worked extra hours some days and worked all weekends to take care of multiple responsibilities towards her immediate and extended family. Jaime, like other African American women in ULH, was perceived as an infinite resource for others, not needing care, and was

expected to be resilient during hardship. Any upward social mobility such as a better job or higher education was associated with more roles and greater expectations from the community. The pressure of having multiple roles was stressful, as were the difficulties associated with performing these roles.

Takesha and her cousin described role strain when asked about sources of stress. Takesha highlighted “not being able to provide for children and family”, and “pressure to come out on the other side” as significant stressors. When asked for clarification about the meaning of ‘pressure to come out on the other side’, Takesha’s cousin who appeared significantly older than Takesha explained that as a Black woman, everyone “dumps all this shit on you and then expect you to deal with it and still be strong.” “Yeah, they say our people are strong, and you bet your ass we are”, Takesha added. “The pressure adds up though, and can really fuck you over”, her cousin stated. Takesha remarked that it was hard for people outside of their community to understand the kinds of pressure they are under but she often depended on other Black women for support.

As a salient stressor among Black women, role strain is related to community expectations. Pressure to fulfil multiple and sometimes conflicting roles to family and society are stressful, yet most women in ULH continued to meet these expectations because they wanted to maintain perceptions of strength that the society has about them, and some felt like they would be letting their community down if they declined some of the responsibilities they were expected to fulfil.

Cultural model of stressors

In addition to stressors obtained from ethnographic fieldwork, cultural consensus analysis (CCA) was employed to identify a cultural model of stressors in ULH. In the first stage of CCA, residents of ULH age 18 and older were approached at different locations in the community and were asked to list all the things they thought cause stress. A total of 52 residents participated. Each participant was selected to ensure maximum variation in the sample in terms of gender, age, and perceived socio-economic status. As shown on Table 5.1, 19 stressors were listed by at least 10 percent of the respondents. Robberies, suspicion from the police, homicides, presence of drug dealers, gun violence and incarcerations were mentioned as sources of stress by a third or more of those who participated in this free-listing exercise.

The second stage of the CCA involved having key respondents rank the significance of stressors generated from the free-listing exercise. Role strain – a salient source of stress identified in the ethnography – did not emerge in the word-listing exercise. To create a universe of stressors that would be rated by key informants, I included two indicators of role strain that were articulated by several residents during the fieldwork: difficulty meeting responsibilities and obligations, and pressure to come out on the other side.

Table 5.1 Stressors listed by respondents (Total number of Participants = 52)		
Stressor	**# of participants who listed stressor**	**% of participants who listed stressor**
Robberies	28	53.8
Suspicion from the police	23	44.2
Homicides	20	38.4
Presence of drug dealers	20	38.4
Gun violence	19	36.5
Incarcerations	18	34.6
Lack of confidence in the government	17	32.7
Racial stereotyping	16	30.7
Homelessness	16	30.7
Poor housing conditions	15	28.8
Unemployment	13	25.0
Employment discrimination	11	21.1
Grief from loss of loved ones	10	19.2
Poverty	9	17.3
Isolation from resources	9	17.3
Lack of opportunities to improve quality of life	8	15.3
Being taken advantage of because of race	7	13.4
Unfair treatment by law enforcement	7	13.4
Underfunded services	6	11.5

This final list or universe consisted of 21 stressors. A survey (see Appendix C) was provided to 40 key informants who were asked to rate the importance of each stressor. These 40 key informants rated the salience or importance (not important, somewhat important, very important) of the 21 stressors identified in the free-listing exercise. These stressors and proportion of key informants who rated each source of stress as not important, somewhat important or very important are presented on Table 5.2

Table 5.2 Importance of sources of stress						
Stressors	**Not Important**		**Somewhat Important**		**Very Important**	
	%	**(n)**	**%**	**(n)**	**%**	**(n)**
Gun violence	0.0	(0)	15.0	(6)	85.0	(34)
Poor housing conditions	7.5	(3)	20.0	(8)	72.0	(29)
Robberies	2.5	(1)	27.5	(11)	70.0	(28)
Presence of drug dealers	2.5	(1)	30.0	(12)	67.5	(27)
Homicides	0.0	(0)	32.5	(13)	67.5	(27)
Racial stereotyping	12.5	(5)	25.0	(10)	62.5	(25)
Grief from loss of loved ones	2.5	(1)	37.5	(15)	60.0	(24)
Incarcerations	2.5	(1)	40.0	(16)	57.5	(23)
Isolation from resources	22.5	(9)	22.5	(9)	55.0	(22)
Suspicion from police	7.5	(3)	37.5	(15)	55.0	(22)
Unfair treatment by law enforcement	5.0	(2)	45.0	(18)	50.0	(20)
Poverty	17.5	(7)	35.0	(14)	47.5	(19)
Pressure to be strong/come out on the other side	20.0	(8)	35.5	(15)	42.5	(17)
Being taken advantage of because of race	7.5	(3)	50.0	(20)	42.5	(17)
Lack of confidence in the government	10.0	(1)	50.0	(20)	40.0	(16)
Unemployment	22.5	(9)	40.0	(16)	37.5	(15)
Difficulty meeting your responsibilities and obligations	15.0	(6)	47.5	(19)	37.5	(15)
Homelessness	5.0	(2)	57.5	(23)	37.5	(15)
Lack of opportunities to improve quality of life	10.0	(4)	60.0	(24)	30.0	(12)
Employment discrimination	7.5	(3)	67.5	(27)	25.0	(10)
Underfunded services	12.8	(5)	66.7	(26)	20.5	(8)

As shown on Table 5.2, all of the stressors identified in the word listing exercise were rated by the majority of key informants as either somewhat important or very important. Sources of stress that were most frequently rated as very important included gun violence (85%), poor housing conditions (72%), robberies (70%), presence of drug dealers (67.5%), homicides (67.5%), and racial stereotyping (62.5%).

Although the frequencies presented here suggest consensus regarding which stressors were considered to be very significant among African Americans in ULH, CCA tested

whether the rating patterns and frequencies were due to individual respondents drawing from the same cultural knowledge of stressors.

The second stage of CCA was to determine the level of agreement regarding stressors among key informants, and to assess if the agreement was sufficient to assume that these stressors were culturally salient, or that a cultural model of stressors existed in ULH. Following CCA methodology, factor analysis of informants using the iterated principal factor algorithm, without rotation, was performed. Results from the factor analysis indicated a single dominant factor. That is, that ratio between the first and second eigenvalues was greater than three to one (Table 5.3). The higher the ratio, the stronger the degree of agreement within the group, and the presence of a single factor solution indicates a shared belief system. As shown, the eigenvalue for the first factor was 27.05 accounting for 95 percent of the variance in the sample. For the second factor, it was 1.67 accounting for about 2.8 percent of the variance. The ratio of the first factor's eigenvalue to that of the second factor is 16.11:1. The ratio clearly exceeds the 3:1 threshold, demonstrating a cultural model of stressors in ULH, or that key informants were drawing from a shared belief system about stressors.

Table 5.3: Factor analysis of informants for sources of stress

Factor	**Eigenvalue**	**Proportion of variance**
1	27.0490	0.9518
2	1.67820	0.2.834
3	0.6349	0.0069
Ratio of 1st to 2nd Eigenvalue 16.11:1		

The final step of the CCA identified items from the universe of sources of stress that constitute the cultural model of stressors in ULH. Since the factor analysis was of individuals and not the stressors identified, the factor loadings (in Appendix D, Table D1) for each individual informant (also known as informant competency scores) represented their correlation with the shared cultural model of stressors in ULH. To determine the stressors that constitute this model, the individual key informant factor loadings were used to weight the responses of each informant in the survey. For example, if a key informant's factor loading for the dominant factor was 0.89, their response (or significance rating) for each stressor was weighted by 0.89. Weighted key informant significance scores for each stressor were calculated and averaged to create a cultural model of stressors for the sample of key informants (see Table 5.4). Stressors with weighted average scores of above 2 (somewhat important) were considered to be part of the shared cultural model of stressors.

As shown, several sources of stress constitute the cultural model of stressors in ULH. Violence and crime (homicides, robberies, illegal drug trade), and associated factors such as incarcerations were substantial components of the cultural model of stressors. Other components with considerable weight included systems of racial discrimination such as racial stereotyping, being taken advantage of because of race, suspicion from police, maltreatment from law enforcement and employment discrimination.

Table 5.4: Weighted average significance scores for stressors	
Stressor	**Weighted Average Score**
Gun violence	2.45
Robberies	2.45
Homicides	2.40
Presence of drug dealers	2.38
Suspicion from police	2.35
Grief from loss of loved ones	2.31
Incarcerations	2.28
Racial stereotyping	2.25
Poor housing conditions	2.23
Unfair treatment by law enforcement	2.22
Being taken advantage of because of race	2.20
Lack of confidence in the government	2.20
Employment discrimination	2.15
Pressure to be strong/come out on the other side	2.13
Unemployment	2.10
Difficulty meeting your responsibilities and obligations (Role Strain)	2.11
Poverty	2.08
Isolation from resources	1.99
Underfunded services	1.95
Homelessness	1.83
Lack of opportunities to improve quality of life	1.80

Most components of this model of stressors were consistent with salient stressors elaborated in the experiences of residents during fieldwork. However, isolation from and the lack of structural resources (poor housing conditions, poverty, and unemployment) though consistent with my personal observations and with objective indicators of stress in ULH, were rarely talked about as salient stressors during informal conversations throughout the ethnography. This is finding is intriguing and suggests that mechanisms such as social comparison that play a role in determining whether conditions come to be described as stressful in ULH may operate differently when individuals are talking about

their conditions (as in the ethnography) than when they are speaking on behalf of a bigger community to which they belong (as in the CCA).

The objective of this chapter was to identify and describe the most significant sources of stress in ULH. Findings from the ethnography and CCA show that ULH residents experience a variety stressors including chronic strains (racism, police harassment and maltreatment, poor housing conditions, unemployment and poverty), daily hassles (fulfilling multiple roles, presence of drug dealers), and sudden traumas (homicides, loss of loved ones). These stressors are salient because they are shaped by the social structure and processes in play at ULH, and the ways by which Black residents develop an understanding of how the world works in ULH. They reflect collective experiences that pose challenges to well-being.

Chapter 6

CULTURALLY SALIENT STRESS RESOURCES AND RESPONSES

Residents of Upper Lake Heights find ways of dealing with stressors in order to help mitigate negative effects of stress on wellbeing. Although traditional stress resources such as mastery and self-esteem are dominant moderators of the effects of stress on health under the stress process paradigm, other resources shaped by the context within which life is experienced in ULH are employed by African American residents. In this chapter, I focus on culturally salient responses to stress and stress buffering resources. As I explore these responses and resources, I address how they are influenced by beliefs, expectations and values that are shared by African Americans in ULH. Culturally salient responses and ways of coping include impression management, John Henryism, and aggression, drug use, and gang membership. Religion and the family are resources often employed to cope with stressful events.

Impression management

Impression management is the process by which people control the impression that others form of them because of their interest in how others perceive and evaluate them (Ashford and Northcraft 1992; Goffman 1959; Schlenker 1980). When faced with stressful events, some residents of ULH employed impression management by acting in ways that seemed like everything was fine, even if things were not going well. The goal was to alter the impression that others might have about them. It was common for some residents to project a self-image and present an identity consistent with how they want to be perceived and not by how people might expect them to be.

One way to manage others' perceptions of oneself is one's physical appearance including clothing. A ULH middle age woman was one of several residents who was intentional about her appearance and used it as a tool for impression management. When she anticipated interacting with White persons, she made sure that she was well-dressed, and avoided being caught off guard. She believed that African Americans are disproportionately and quickly judged, and, as such, dressing up well and maintaining a good physical appearance were important ways of creating a good impression, regardless of what one might be going through.

Josh provides another example of impression management by being intentional about what he wore and how he wanted to portray himself. He had learned from his grandmother that looking good affected how others perceived an individual, and determined the kinds of things a person might attract into their lives. Josh lived by these beliefs and was passing them on to his son. He was taking his son to get his hair braided. "I'm teaching him from a young age to look good. Bling. Put on that swag and look good", he said. "No matter what shit you're dealing with. That is what my grandma told us." "Girl, she'd put on make-up, jewelry, wear her some fancy clothes on the day her car got repossessed." Josh explained that it was important for his family to always look good, and to look happy even when things were rough. There were two reasons for making a conscious effort to look nice when things were hard. The first, Josh said, was "to feel good, appreciate yourself and your efforts in life." The second was "to let the situation, other people, the world, know that you cannot be broken by that shit." Intrigued, I asked if he would intentionally dress up nicely, look and act as if everything was fine after losing his job and was unable to pay his rent. "It's a demonstration of faith.

Strength because I remain strong, happy, it will guide me to success", he responded. "If you look ragged, you attract poverty, you appear broken." Certain things such as renting a good apartment have worked better for Josh than for one of his friends who "lets shit weigh him down and won't quit sagging his jeans." It was an approach he had tested, and it was working for him.

Physical appearance including choice of clothing is a more passive form of impression management. Individuals ascribe certain characteristics and attributes to looks. These attributions can be made without necessarily having knowledge of the stressors that an individual might be experiencing. Individuals still employ impression management to be perceived in a certain manner regardless of whether they are going through stressors or the persons to who they are presenting are aware of their conditions. More active forms of impression management are likely to occur when individuals who are experiencing a highly stressful condition express positive attitudes with respect to that particular stressor. In instances like this, others who have prior awareness of an individual's exposure to such stressors may expect the individual to be affected by the stressor in one way or another. As such, they might form perceptions and expectations about the individual. The individual can actively employ impression management for the specific purpose of demonstrating that they are not as affected by the stressor as might be expected. As part of impression management, individuals might choose to present narratives and attitudes that are in direct contrast to what others would expect given the specific stresses they are experiencing. These might include strong positive attitudes towards highly threatening events.

Twenty-two year old Tammy, a nursing student who had suffered significant losses coped with stressors by employing impression management to focus on the positives, and to discredit any negative stereotypes about her. She shared that when she was in the foster care system, she didn't have anyone who understood her or got what she was dealing with emotionally after her parents were shot. As I began extending my sympathy for what she had gone through, she interrupted with a smile, firmly stating that: "Yeah, but everything that happened contributes to making me who I am now." "There is no crown without a cross." Tammy further explained that at that time, she was somewhere between the cross (a biblical reference for suffering that produces great reward) and the crown - meaning that although she had gone through suffering, it was ultimately a positive thing because she learned the perseverance needed to get the rewards (the crown) that she had labored for. Most of her focus was on her achievements and plans to become even more successful. She intentionally redirected the conversation from her stressful experiences to what she had achieved.

I was surprised by the resilience that she seemed to have, given what she might have gone through. She was upbeat, positive, and was working hard to help other people who might be experiencing what she went through. Although she talked about people not understanding her emotional state when she experienced traumatic events, she seemed to be intentionally dismissive of how traumatic or stressful these experiences might have been. She did not want to listen to me tell her how sorry I was that she went through the things she went through. She had put a positive spin to everything she had been through, appraising the events that happened to not be as devastating as some might expect them to be.

Two weeks later, Tammy and I had dinner together at one of the local diners. She shared some of her experiences, and how she had kept her symptoms of mental distress from clinicians, social workers and numerous foster parents. They often assumed that she was doing fine: “cos I’d sing even though I got it real bad. Ain’t no crying, girl!”, she said. I asked her why she would not cry, and how she would be singing, and seem very upbeat after going through some of the horrendous things she had finally shared with me. “I needed to be strong, is what my mom and dad, and my grandma expect from me”, she responded. She later on said that she believed sharing her fears and sadness might have made them real. It was easier for everyone to like her when she was strong, singing, swallowed her fears, fought back her tears, and pretended that everything was okay. She felt that things would be easy if she did not appear to be “weak and desperate.” “They expected me to be messed up and completely fucking helpless,” she said.

Tammy, like most people who I got to know, was intentional about managing the impressions that people had of her. She was invested in how she was perceived by specific persons in her life. Tammy compared possible outcomes of presenting a “real” self, one that meant acknowledging the pain and anguish from losing her parents, with the potential outcomes from acting like she was doing well. She perceived more desirable outcomes from presenting herself in a positive light and by minimizing the degree to which stressful events had affected her life. Impression management helped her achieve the outcome she believed was important to her, and not what others expected from her circumstances. Tammy’s ability to present a favorable image to others also limited the degree to which she and others focused on the stressors she was experiencing, as well as on their effects.

In general, the need for impression management in ULH is related to the fact that Blacks in the U.S. exist within a system where 'Blackness' and its social attributes are discrediting (Feagin 1991; Harlow 2003; Howarth 2006). This context influences how Black persons interpret and react to negative experiences. In ULH, I found that most Black persons became intentional in negotiating how responses to stress influenced how they were perceived in the broader society. When exposed to stressors, most Black residents employed impression management to deal with stress in ways that counter stereotypes about them.

John Henryism

Although some historians have argued that the story of John Henry was not a tale, John Henry is still commonly known as an African American folk hero who raced and beat a steam-powered hammer in the task of hammering steel drills into rock. Even though he won, John Henry died from the stress he suffered in the process. Scholars use John Henryism to describe a high effort, strong drive, and persistent determination to surmount chronic stressors. In ULH, John Henryism was a common response to stress. People were expected to be persistent in their efforts to overcome the various stressors that surrounded their existence.

Tammy's case is an example. Despite her continuous exposure to significant stress, she forged ahead with the determination to be successful with limited structural resources. Tammy was clear that expectations to persevere were shared by her family, and was passed on to her as a child when her parents and grandparents were still alive.Tammy believed that expectations to press on and to be strong even when it might have been to

one's own detriment were held by African Americans and not Whites. "Now, I'm thinking if I had a Black therapist or social worker, they'll see right through that shit", she stated. When I asked how a Black therapist would have known that she was not doing well, she responded that: "They'll understand that I was just trying to be what everyone wants me to be, a strong confident girl."

The story of Donald, a young father and husband, is also illustrative of John Henryism. Donald worked two warehouse jobs. He worked 18 hours a day on week days; lifting, moving, and packing up to 70 pounds, and was expected to stand, bend or stoop his entire shifts. He also worked five hours every weekend cleaning windows of commercial buildings, a job in which he reported experiencing racial microagressions such as having his supervisor say that he worked hard considering that he was a Black male. Although Donald's wife was worried about how hard his jobs were on his ailing health, he himself felt that he needed to "continue to bring home the bacon and stay on top of things so no one's gonna say this brother's lazy." "We was taught to persevere through shit like this for things to get better. I'll soon be doing well for my family, as you can see. I can't sit on my butt and do well", he said. When his wife explained that they could get by without him working three labor intensive jobs, and suggested that he at least quit the weekend job "with the racist manager", Donald asked: "Where's the determination? You gonna stop asking me cos you know I've put my mind to it. That's how I was raised."

An older woman articulated the cultural value of this kind of determination among African Americans. Jackie was a 77 year old woman who was very active in her church and in neighborhood programs geared towards securing safe spaces for women and

youth. She was curious about the circumstances of African-born Blacks both on the African continent and in the United States. In one of our conversations, we compared the values and ideals of Blacks across continents. I asked her about the values and principles she believed were common among and perhaps specific to African Americans. Without hesitation, she said “we keep on pressing on.” She talked about how she herself had persevered through sickness and problems with her children who were “going astray”, but has kept going because of God. According to her, the fact that African Americans have persevered through a lot of terrible things that were done to them “speaks volumes about their values and ability for survival. No other people can do that. They’ll fall like leaves.”

Pressing on through high effort coping often involved the hope that things will get better, and that one day, the community and its members would overcome collective and individual troubles. “A positive mindset is what keeps our people going during tribulation. If you take that away, if the mind is messed up, then you are going to fail”, said a women who was grieving the death of her parents. The hope that things will get better, often echoed by community leaders at public events, was shared by people in all walks of life. They constantly told themselves and others to “keep moving on”, “keep pressing ahead”, despite some unimaginable difficulties. These cultural expectations around how to deal with stress, required a demonstration of strength, confidence, and perseverance that might ultimately be harmful to the individual.

Aggression, drugs, and gang membership

Other responses to stress common in ULH were drug use, joining a gang, or engaging in aggressive behaviors and in violent crime. Parents would often express worry about the possibility that their children might join gangs as a way to cope with difficult situations or to retaliate against police victimization. A Vietnam War veteran, Michael, was concerned about how his twelve year old grandson would deal with the salient stressors in ULH. When we talked, Michael was in a motorized wheelchair; his jacket and his hat were visibly dirty. There was a large black bible in the carriage of his wheelchair. He lived about five blocks to the north of the street corner where we waited for the bus.

We heard what sounded like three gun shots. I was afraid. “What was that?” I asked. “Gun shots child, gun shots”, he responded, very casually, with a straight face and an unconcerned look. He was worried about being late for church. Normally, someone from church would give him a ride, but their son had been involved in a fight and had gotten shot in the leg. The fight and shooting had occurred at the intersection where we spoke. I shared some of the stories I had heard about shootings and gangs as I had not witnessed any yet. “Is it really that bad or are people exaggerating?” I asked. “The kids here are not going to inherit nothing. So they’re on the streets. We’re used to it. It isn’t that bad”, he responded. “But we pray for them youngsters… they begin using drugs early”, he said sadly. He was determined to keep his grandson from “drugs and the bad guys”.

The bus finally arrived and we got on. I sat next to him as we continued the conversation. I told him that I was a student interested in how people deal with things that may be stressful. At that point, I took out my notepad and was ready to write his responses as he

spoke: “You gonna quote me?” he said excitedly. “Maybe. If you don’t mind. But I’m writing so that I don’t forget”, I responded. In responding to my question on dealing with stress, he said “some folk just don’t, other folk get frustrated then do what they know to escape the problem, do drugs and more drugs. Other folk pray for the best.”

I was asked for and offered drugs several times in ULH, both from persons who I frequently interacted with and from others who I met for the first time. For those who were open about their drug use, they were clear that the drugs were for calming them down or providing an escape from their current troubles. People frequently talked about alcohol and substance use - lighting a bowl, smoking a joint, using crack, and getting drunk - in the context of dealing with stressors. I asked a middle age man how he dealt with violent crime in ULH. “Smoke me a bowl to calm me down”, he responded. Shannon provides another example. I first met her at a basketball game with her teenage son. They had moved to ULH from a larger city only two years ago because Shannon had lost her job as a teacher because of “discrimination and shit.” She was smoking cigarettes and had offered me some. When I declined the offer, she said: “I have some killer weed if that’s your choice, but it don’t come free.” When I turned down marijuana, she explained, at minimum, why it was that she smoked marijuana: “Shit happened!” Shannon was well aware of the health consequences of cigarettes because both her parents had died from lung cancer. “When they say cigarettes can kill you, they mean that it can fucking kill you”, she said as she exhaled smoke from her cigarette. Shannon explained that she smoked cigarettes and marijuana to deal with the stress from job loss and from the death of her parents. “That’s why I do this, and weed too, they calm my

mind and keep me going – bubbly and happy. Don't know what works for other peeps but this shit has saved my ass."

Racial stereotypes also triggered substance use among some individuals who I encountered. "If you was a Black man and everyone thought you'll shoot them, how will you live with that shit….being followed and all? You'll do drugs, join gangs and then soon, you start fulfilling the stereotype", stated a longtime ULH resident. Nevertheless, substance use and gang membership were not usually perceived as appropriate ways of dealing with stress but were employed because they provided a sense of immediate escape from stressors and accentuated feelings of being in control of one's circumstances. An elderly man who had lived in ULH his entire life and who in his youthful years was a member of a gang was emphatic that he had joined the gang because of homelessness. He did not feel like anyone cared about what he had suffered in the hands of the police, most of which were a result of his race and social class. Being in a gang was the only place where he felt like he was in control. He was able to escape feelings of frustration, and learned how to survive poverty and homelessness, and to counter police victimization in his own way.

Tom, when his parents died, dealt with that loss by engaging in aggressive behaviors. "I became so aggressive. I wanted to punch any motherfucker that stood in front of me. Punched a few of them. It felt fucking good that time", he had said. Aggression was considered strength by some men and women, and was also thought of as a way of demonstrating that one was not falling apart or being "pressed down" by stressors. During a conversation about aggressive behaviors of Black men, I specifically asked a

Black woman about appropriate or expected ways by which Black men would typically deal with something that causes them stress. “Our men come in all kinds; angry, aggressive, sweet, mamma’s boys. But you know what’s real when shit hits the fan. They get aggressive, tough. Get it under control.”

Religion

Residents of ULH frequently employed religious coping to deal with stressors. There are three main ways by which religion was used as a resource to cope with and to make meaning of stress. First, religion enabled residents to let go of problems and surrender to a higher power. Second, religion provided guidelines on how to handle and respond to stressful circumstances. Participation in rituals such as prayers, meditation, and testimonies generated positive emotions. Third, religious participation itself provided companionship, emotional and instrumental support that helped individuals deal with stressful circumstances.

Surrendering to a higher power meant that people understood that they were limited in their ability to resolve stress and had to stop worrying. Most residents of ULH felt that because events in their lives were controlled by a higher power that had their best interests, stressful events ultimately happened for a good reason. For example, after a tragedy that took the lives of several children, vigils and meetings were held in which the entire community was continuously comforted by their understanding that God - a higher power- knew best, and that the tragedy although unspeakably sad, would serve a good purpose. Although Tom neither considered himself religious nor attended church regularly, he described the event as one of the trials from God that everyone went

through, and that such trials demonstrated and strengthened trust in God.Tammy's biblical reference of no crown without a cross also demonstrated how ULH residents believed that good things eventually came after bad things. The cross, though a religious symbol of suffering, was a necessary step to get to the crown. Beliefs that a higher power controls the events of one's life, and that stressors serve a good purpose helped persons experiencing stressful events to deal with and make sense of negative events.

Practicing a religion or being a part of a community where religion plays a strong role in daily life meant that one deliberately or inadvertently adhered to religious guidelines about life. Residents of ULH often referred to biblical stories about how people dealt with stress, and brought up specific biblical recommendations for dealing with difficulties. I attended dozens of religious events and meetings in ULH. In one of such meetings, Jackie indicated that they would focus on verses that "provide the spiritual guidelines for dealing with hard times". One of the verses selected was Philippians 4:6-7, and it read: "Do not be anxious about anything, but in everything by prayer and supplication with thanksgiving let your requests be made known to God. And the peace of God, which surpasses all understanding, will guard your hearts and your minds in Christ Jesus." Each person took a turn sharing what the verse meant to them.

One woman's reflections on the verse demonstrated that religious responses to stress in ULH were essentially directives believed to be provided by God. She was one of Jackie's relatives. She explained how important it was to remember that God was commanding them to not be anxious about anything. If they chose not to obey that command, they were bringing worries upon themselves and it was no longer God's problem. She added

that in the midst of hard times, they had a choice- they could either choose anxiety or choose to let the peace of God fill their hearts. In response, another woman said that God did not promise anyone an easy life with no problems. But “he made a way for us to always come out victorious in the end.”

In addition to dealing with stress by adhering to religious guidelines, people often obtained support from their church communities. Most ULH churches were described as spaces where residents felt welcomed, and from which they had received support regardless of their membership status. Whenever I went to a church, I too was warmly welcomed and felt like I belonged there or was a long time member. People smiled at me, asked how I was doing, and had conversations while waiting for the service to begin. Everyone seemed genuinely happy. The happiness was contagious, and church seemed a perfect place where ULH residents found support. Most of the time, members of a congregation who had difficult times such as a child in jail, an illness, problems with a landlord, or problems with law enforcement officers were mentioned by name and prayed for. In some cases, the minister asked for people to volunteer to go and visit with members who were going through difficulties. Several community members talked about how the church or individuals they knew through church had helped them with resources such as food, money, a place to stay, clothing, rides to medical and other important appointments, and job leads.

In general, religion played an important role in the lives of ULH residents. Believing that a higher power controlled events in one’s life made it easier for some residents to stop worrying about stressors and to pray to such a power to meet their different needs. Prayer

was therefore a means by which individuals themselves coped with stress. It was also a way by which some felt that they supported others in the community. People felt better about things or about their ability to deal with negative events when they knew that others were praying for them. Hence, beliefs that God ultimately had a good plan even when something bad happened, and that the church community would support through prayers, cash, and other charitable services shaped how people in ULH dealt with stressors.

Family

The family, especially including the extended family, was an important resource. One ULH man stated that health "comes from the strongest part of the community which is family. Family is together, everyone is happy, everyone is healthy and strong." The family was perceived as the source of all good things; a place where people went to for support, understanding, and nurturing. When dealing with difficulties such as job loss, an illness, and forms of racial discrimination, family members were often one of the first people residents of ULH would turn to for material and emotional assistance.

Sometimes, support from the family meant preserving a person's image, and the family's image by extension, as illustrated in one of my conversations with Jackie. Jackie was always excited to share with me what she considered to be Black or African American culture. She said that African Americans often took care of their own – something I had heard several times from other community members. According to Jackie, things were often kept in the family because it was important to protect the image of the family. Jackie provided an example to support the point she was making. She stated that if her

child was doing drugs, she would keep it in the family and try to find help from within because as much as she would like to enroll him “in some government program” and to “shame him into changing”, people will often link his crime or behavior with his family, and may even attribute it to poor upbringing. “People don’t want their family to be disgraced.” Because the family was a significant resource to deal with stress, people frequently employed impression management to preserve the image of their families.

Other times, help from family was simply the opportunity to “hang and chill”, and to share meals. Families did not necessarily remain within the confines of their homes where big meals or cook-outs were usually prepared for extended family members. They also went to local restaurants to eat together, especially when something stressful happened. A diner that had made a name as one of the local favorites was a popular eating spot where families and friends congregated to share meals.

There were days when I visited this diner more than once- mostly because it was a good meeting place, but also because the food was really good. I had a brief conversation with one of the staff, an African American female who appeared to be in her early twenties. Throughout our conversation, she referred to the food as “greasy fix”. I asked if the food is referred to as comfort food because of its greasiness. “Yes, and it’s extra tasty”, she responded. She added that the owner had a lot of support from the community because “tasty comfy food” is one of the things people need to deal “with some of the stuff that goes on around here”. “What kind of stuff goes on around here?” I asked. “Like if someone gets mugged, or a guy got shot. Folks takes them here. They can eat a helluva comfy meal for under 5 bucks.”

Although comfort food was described in the above conversation as a way of coping, it became clear later in the ethnography that eating food was a social event geared towards getting families together. The comforting or stress-reducing aspect of food was not inherent in the nature of the food such as its perceived greasiness. Instead, it came from a familial bond that strengthened when people ate together in a context that ultimately improved mood and affirmed social support. Jackie and several ULH residents talked about food in the context of sharing love, fostering family bonds and maintaining connections. “Food brings we all together”, Jackie said. “I have a open door policy that when I cook, anyone is welcome to eat”, she continued. Having an open door policy and cooking for extended family members was common. In ULH, food was embedded in the family, the family being the stress resource.

Cultural model of stress responses and resources

CCA was employed to identify a cultural model of stress responses and resources in ULH. As with the case of stressors, residents of ULH age 18 and older were approached at different locations in the community and were asked to list the things people depended on or did when they were dealing with stress. Participants were selected to ensure maximum variation. A total of 49 residents responded to this question, and 19 responses were listed by at least 10 percent of the respondents. These responses and their frequencies are shown on Table 6.1

Stress responses and resources listed most frequently by residents included having faith in God, friends and family, pressing on even when it is hard, praying, and maintaining a positive mindset. A final list or universe of stress responses and resources consisted of 24

items. Five additional items were included on the list. One of these items was gang membership. Gang membership did not meet the 10 percent frequency requirement in the word-listing exercise but emerged as a salient stressor in the ethnography. Two items indicating impression management: acting like the problem does not hurt and behaving like everything is going well were also included in the universe of stress responses. Mastery (having control over your life), and self-esteem/self-confidence, traditional psychological resources in the stress process were also included on the list.

Table 6.1 Stress resources and responses listed by respondents (# of Participants = 49)

Stress resources and responses	# of participants who listed item	% of participants who listed item
Having faith in God	21	42.8
Friends and family	19	38.7
Pressing on even when it is hard	16	32.6
Praying	16	32.6
Maintaining a positive mindset	13	26.5
Church	12	24.4
Working hard	11	22.4
Being hopeful	11	22.4
Rap Music	7	14.2
Joining social groups	6	12.2
Perseverance/determination	6	12.2
Frequent family get together	6	12.2
Meditation	5	10.2
Being assertive/standing up for yourself	5	10.2
Money	5	10.2
Support from other Black people	5	10.2
Comfort food	5	10.2
Playing sports	5	10.2
Drugs and alcohol	5	10.2

In Part 2 of the survey, the same 40 key informants who rated the salience of stressors rated the degree to which each of the 24 stress responses and resources was common

among African Americans in ULH. The ratings were: not common (1), somewhat common (2), or very common (3).

Table 6.2 Prevalence of stress resources and responses			
Resources and Responses	**Not Common**	**Somewhat Common**	**Very Common**
	% (n)	**% (n)**	**% (n)**
Praying	2.5 (1)	20.0 (8)	77.5 (31)
Friends and family	0.0 (0)	25.0 (10)	75.0 (30)
Acting like the problem doesn't matter/hurt	10.0 (4)	20.0 (8)	70.0 (28)
Being hopeful	2.5 (1)	30.0 (12)	67.5 (27)
Perseverance/determination	2.5 (1)	30.0 (12)	67.5 (27)
Pressing on even when it is hard	5.0 (2)	22.5 (11)	67.5 (27)
Behaving like everything is going well	2.5 (1)	37.5 (15)	60.0 (24)
Maintaining a positive mindset	2.5 (1)	42.5 (17)	55.0 (22)
Playing sports	15.0 (6)	35.0 (14)	50.0 (20)
Being assertive/standing up for yourself	2.5 (1)	47.5 (19)	50.0 (20)
Frequent family get together	0.0 (0)	50.0 (20)	50.0 (20)
Support from other Black people	2.5 (1)	50.0 (20)	47.5 (19)
Having faith in God	0.0 (0)	52.5 (21)	47.5 (19)
Having control over your life (mastery)	10.0 (4)	42.5 (17)	47.5 (19)
Rap Music	25.0 (10)	30.0 (12)	45.0 (18)
Working hard	10.0 (4)	45.0 (18)	45.0 (18)
Self-confidence/self-esteem	5.0 (2)	50.0 (20)	45.0 (18)
Church	2.5 (1)	52.5 (21)	45.0 (18)
Money	37.5 (15)	25.0 (10)	37.5 (15)
Comfort food	10.0 (4)	52.5 (21)	37.5 (15)
Drugs and alcohol	52.5 (21)	12.5 (5)	35.0 (14)
Meditation	0.0 (0)	65.0 (26)	35.0 (14)
Gang membership	30.0 (12)	37.5 (15)	32.5 (13)
Joining social groups	50.0 (20)	25.0 (10)	25.0 (10)

Table 6.2 shows the stress resources and responses identified, and the proportion of key informants who rated them as not common, somewhat common, or very common. Stress resources or responses that were most frequently rated as very common among African Americans in ULH included praying (77.5%), support from family and friends (75%), and acting like the problem doesn't matter (70%). However, a half of the key informants felt that joining social groups and using drugs and alcohol were not common ways by which African Americans dealt with stress in ULH. Cultural consensus analysis (CCA) tested whether these rating patterns were a result of individual respondents drawing from the same cultural knowledge of stress resources and responses.

Following methods for CCA, factor analysis was conducted to determine if the level of agreement about resources and responses among key informants was sufficient to assume cultural salience, or that a cultural model for dealing with stress existed in ULH. A factor analysis of informants using the iterated principal factor algorithm, without rotation, indicated a single dominant factor. That is, that ratio between the first and second eigenvalues was greater than three to one. The higher the ratio, the stronger the degree of agreement within the group. In CCA, the presence of a single factor solution is indicative of a shared belief system. In this analysis, the eigenvalue for the first factor was 28.42 and for the second factor, it was 0.91. This indicates a ratio of 31.14:1 which clearly exceeds the 3:1 threshold (Table 6.3). Therefore, there is a cultural model for dealing with stress in ULH, or key informants are drawing from a shared belief system about stress resources and ways of responding to stress.

Table 6.3 Factor analysis of informants for stress responses and resources		
Factor	**Eigenvalue**	**Proportion of variance**
1	28. 42557	0.9509
2	0.91276	0.0377
3	0.40822	0.0129
Ratio of 1st to 2nd Eigenvalue 31.14:1		

Items from the universe of stress responses and resources that constituted a cultural model for dealing with stress were identified. The factor loadings (Appendix D on Table D2) were used to weight the responses of each informant in the survey. For example, if a key informant's factor loading for the dominant factor was 0.99, their response (or significance rating) for each resource or response was weighted by 0.99. Weighted key informant significance scores for each resource or response were calculated and averaged to create the items considered to be collective ways of dealing with stress in ULH. The resources or responses with weighted average scores of above 2 (somewhat common) were considered to be part of the shared cultural model of dealing with stress. Table 6.4 indicates the weighted average rankings of stress resources and responses.

As shown on Table 6.4, residents of ULH drew from several resources when experiencing stress. Culturally salient resources such as extended family members and friends, church, support from other Black people, playing sports, and frequent family gatherings entailed some degree of social interaction with other persons within a given

network or community. The community itself can be perceived as a resource for individual members. Praying, being hopeful, maintaining a positive mindset, having faith in God, and meditation had high cultural significance as stress responses in the CCA, and also emerged under the broader theme of religious resources that was identified during fieldwork.

Table 6.4 Weighted average significance scores for stress resources and responses

Resources and Responses	Weighted Average Score
Friends and family	2.55
Praying	2.50
Being hopeful	2.47
Perseverance/determination	2.45
Maintaining a positive mindset	2.44
Pressing on even when it is hard	2.43
Being assertive/standing up for yourself	2.43
Acting like the problem doesn't matter/hurt	2.42
Behaving like everything is going well	2.40
Having faith in God	2.38
Working hard	2.35
Self-confidence/self-esteem	2.32
Church	2.29
Frequent family get together	2.28
Support from other Black people	2.27
Having control over your life (mastery)	2.25
Playing sports	2.22
Meditation	2.20
Money	2.05
Comfort food	2.00
Rap music	1.95
Gang membership	1.90
Drugs and alcohol	1.88
Joining social groups	1.98

In general, most of the high significance components of the cultural model of stress responses in ULH indicated broader themes identified in the ethnography. For example, perseverance and pressing on during hard times are indicative of John Henryism. Similarly, acting like an existing problem does not hurt, or behaving like everything is

going well (and there are no problems at all) are indicative of impression management. Gang membership and drug and alcohol use, although identified during the field work as common ways of dealing with stress, they did not constitute the cultural model of salient responses and resources identified in CCA.

The objective of this chapter was to describe culturally salient stress resources and ways of responding to stress. Findings from the ethnography and CCA show that ULH residents employed a range of personal and social resource to deal with stress. Interestingly, structural resources such as wealth and income, having a good job or owning a home or car were not salient resources believed to alleviate the negative impact of stress. Examples of personal resources in ULH include the ability to maintain a positive mindset, to persevere and to be hopeful, as well as prayers and medication. Social resources include the church, family and friends, and solidarity within the Black community. However, not everyone had access to or could summon these resources, and sometimes, these resources were neither sufficient for nor efficient in managing stress. Therefore, some residents engaged in substance use, violence and aggression in hopes to cope with stressors, and to gain a sense of control over their lives. Unfortunately, this might expose them to more stress, leading to stress proliferation. Responses to stress and stress resources described in this chapter are shaped by structural and contextual factors that affect the daily lives of Blacks in ULH. As Black residents summon these resources, they act as cultural agents trying to make sense of their collective experiences and deciding what the best ways to mitigate the effects of stressors on the families and communities.

Chapter 7

MEANINGS AND EXPRESSIONS OF MENTAL HEALTH PROBLEMS

Poor mental health is one of many outcomes of long-term exposure to stress. In Upper Lake Heights (ULH), few persons I interacted with believed mental health problems to be medical conditions with specific organic or physical causes. Much of the discussion around mental health was in relation to an individual's emotional strength or their ability to handle themselves when under stress. Mental health problems were described and understood in the context of a person's abilities and roles within their community. The meanings and attributes of mental health problems in ULH shaped how people expressed distress, and determined the words and symptoms used to describe experiences of depression - one of the most common mental disorders in the United States. This chapter describes the meanings of mental health problems in ULH and identifies culturally salient indicators of depression.

Meanings of depression and mental health problems

Most residents of ULH often considered mental health problems to signify weakness. When asked directly, people were uncomfortable talking about their own mental health or about mental illnesses, in general. Yet, they would address their physical health problems such as diabetes and cancer casually in conversation. When talking about others who might have experienced symptoms of mental health problems, the people I talked with almost always referred to these persons as weak, or inferred that their conditions were a result of some form of weakness.

Jacob was an older man who used crutches to walk due to injuries from a recent car accident. Both he and his wife Lucie had been on supplemental security income disability for over a decade. They both had chronic health conditions. Jacob and Lucie both talked about how strong the other was, and how much they have been able to achieve despite their physical health. Because both their disabilities were visible, I initiated a conversation about more invisible disabilities, especially severe mental illnesses. “Yeah, brain damage or some messed up shit where you hear voices, that’s the fucked up stuff there”, Jacob commented. As we continued the conversation about severe mental disorders, I asked their thoughts about how people generally dealt with problems such as severe depression. “Oh honey, Black folk don’t get no seVERE depression”, said Lucie. Jacob later on acknowledged that he sometimes had “some distress going on” but never severe depression. To Jacob and Lucie, depression, as other mental problems, mostly depended on an individual’s “inner strength”, and on “how you handle shit that life throws at you.”

It was difficult for people to acknowledge or talk about their own mental health problems. Jerome was the first of several homeless persons I interacted with who talked about mental health. He was an older Black male in a mobility scooter who approached me and asked how I was doing. Jerome had a thick and full grey beard and no teeth, at least none that were visible. His large hoop earring was sitting on his left shoulder where a conspicuous snake was tattooed. There were several holes on his black sleeveless t-shirt, and his leather boots were torn on several spots. When I looked into the scooter carrier, I saw random things including a shaving blade, a bottle opener, priority mail envelops, a cigarette box, and a Redbox dvd. I asked him how he was doing. He

responded that he was trying to collect some spare change so he could pick up his prescription. As we continued the conversation, I asked Jerome how he was feeling, how his health was doing. “Pretty bad, but I’m good with it, you know what I mean. I’m used to it”, he responded. He talked about several medications he was taking and comfortably shared details about his physical health.

But Jerome seemed surprised when I asked to know his thoughts about mental health and mental illnesses. “I got the brain damage since I was born, but I’m not psycho crazy, you know what I’m saying?” he responded. I could tell that Jerome felt that I might have assumed that he had a mental health problem, which in his mind, was different from brain damage. Because it was so important for Jerome not to be perceived as having a mental illness, he clarified that his case of brain damage was different from “folks who don’t get it together because of no morale. They ain’t got any strength.” He added that he was not saying it was all their fault, but “at least their brain works well”, and they can “feel good coming out of that shit when they’re willing, you know?” According to Jerome and others in ULH, persons with mental health problems have them because they are weak.

The case of Lory provides another example where mental health problems were thought of as a sign of weakness. She was a young woman in her early thirties, and was one of few people with who I interacted who was open about having depression. Lory had been on medication for depression for over a year, and exercised regularly as a means to manage her mood. For her, taking medication was a big step. “I was tough growing up. It felt like I had lost that when they gave me the medications.” Lory was frustrated with herself after her diagnosis and especially after she was prescribed antidepressants. She

said: “I thought how I could have let negative stuff get to me to the point that I am now a depressive.” Although Lory felt like she had finally understood that her depression was neither due to something she had done nor was a sign that she was “no longer tough”, she stated that in her community, people think you “make yourself mentally ill by choosing to give into problems.”

Expressing distress through sadness was also perceived by some to be a sign of weakness, and for some men, such behavior was at odds with normative masculinity. Several years ago, Tom spent eight months in a juvenile prison for possession of marijuana and for shoplifting. I asked him what the hardest part about being detained was. “I disappointed my folks, especially my mom”, he said. “I failed them by dealing drugs and going to jail. But they were more disappointed when I came out and did not try to better my life.” Tom was arrested again when he was 19 and spent three years in jail. Unfortunately, both his parents died when he was in jail. His dad was shot by a kid who was high on drugs because “he was in the wrong place wrong time” and Tom’s mom died shortly after from diabetes-related complications. I asked Tom about his mental health when he was in jail and losing his parents. I asked if he was very worried, stressed, very sad or depressed. “Very disappointed in myself. Not depressed or messed up in the head, you know. I had faith in myself and in God that I would get out of there and not go back.” “How about when your parents died?” I asked. After considerable silence, Tom responded: “I was devastated. It was the first time I cried like a girl. When my mom died.”

Analyzing Tom's response to the question about his mental health in relation to the stressors he was experiencing was informative. When directly asked if he was sad and worried, he did not believe that the disappointment he felt was sufficient to warrant sadness. In general, he did not describe his experiences as sad partly because he felt responsible for being in jail and rather than being sad, it was easier and more appropriate for him to be disappointed in himself. Sadness was not something that affected strong people. Several months later, we revisited this conversation. Tom described his emotional state as being "solid as hell", and argued: "If I said yes I'm sad, then you'd think I was depressed. For real, I wasn't sad about my condition. But I was disappointed with myself." "The attitude is different. It was a wakeup call that I had to get my shit together." His initial reference to depression as messed up in the head, and his later assumption that acknowledging sadness meant that he was depressed conveyed expectations around expressing vulnerable emotional states. Tom could have easily said that he cried so much. However, saying that he felt like a girl for crying portrays gender expectations regarding the manner of expressing sadness. Similarly, I was standing beside a man, his wife and their toddler during a funeral in ULH. The man was crying profusely but at the same time, he apologized to me for "being such a mess." When I responded that he didn't need to apologize, his wife leaned over and whispered to me: "My friends and his friends make fun of him for being a softy."

Several women talked about crying as inconsistent with notions of strength. Tammy claimed that she never cried at all because as a Black woman, she needed to be strong. Ellen was in her late forties but has only been crying recently because of the death of her brother. She "just did not know how to." When she experienced extended crying spells,

she made sure she cried only privately, and made certain that I was not associating her emotional state with depression. “They say crying helps. I’ve been crying for a month now. Sure as hell ain’t helping.” I suggested that since she had been crying daily for a month, she might want to talk to someone at a local clinic. “You think I’m depressed? Fuck you!” she said jokingly, but added that she might “talk to a head doctor”, if she had to. Both crying and depression were inconsistent with narratives of strength and were indicative of weakness.

Some individuals did not consider depression to be a sickness that they should be worried about. For example, Albert, a 56 year old man who was open about his physical health problems shared his excitement that “for the first time in a while, I look good and feel good.” He had recently received a positive prognosis from his doctor regarding his health condition. This was possible because he had just been recently insured as a result of the Affordable Care Act. He explained that he signed up for insurance because both he and his wife feared that because of his family history and current health condition, he was at of risk of having a heart attack. I asked if he had similar concerns with respect to experiencing mental health problems and not being able to seek treatment because of lack of insurance. “Mental health? Like was I depressed and stuff?” He looked rather surprised by the question, although I had told him that I was a mental health researcher. “First. Depression? That is not even a real sickness. It’s no heart failure”, he said, dismissively. “I don’t need insurance or some goddamn stranger to tell me what’s up with my mind.” He added that he did not really care about his mental health because he had never been depressed but that if he was depressed, he would be “rapping and chilling” with his friends to “get a buzz on.”

Albert, like some others I interacted with felt that individuals should be able to understand and master their own mind. Acknowledging mental health problems might mean that individuals would allow someone else to evaluate their mind and assess if there is something "wrong" with it. In addition, the assumption that depression can be easily fixed by spending time with friends to "get a buzz on" might foster reluctance in accepting or perceiving depression as a medical condition that might need medical interventions.

Perceiving mental health problems as signs of weakness may lead some African Americans in ULH to conclude that a person with a mental disorder or a symptom of distress is not strong enough to handle problems. Thus, people with mental health problems are frequently looked down upon for not holding up to the ideals of strength and resilience that characterize the Black community in ULH. A Black minister and his wife who claimed to speak on behalf of the community stated that: "Our people see mental illness as a sign that one possesses no inner strength, and seeking out help means one is unable to handle himself well." "And therefore, he cannot be entrusted with the responsibility of handling the affairs of others", his wife added. Even though this minister clarified that he personally did not believe that a mental illness was entirely a sign of weakness, it was hard not to "question the strength and psychological stability of one of our own known to have a mental illness."

Mental disorders were also conceptualized as signs of individual failure and as a source of shame. I was in church when Becky, a woman in a wheelchair, came to the front to talk about the healing that she had experienced. She was accompanied by her daughter

who seemed to be between the ages of 8-12. Becky had been suffering from severe anxiety and depression since she was teenager. Her description of her experience with mental health problems was that “the devil was trying to steal my joy,” because “I allowed it to happen by disconnecting myself from God.” Becky had turned to drugs and alcohol which helped her mask some of her symptoms but also then made her more ashamed of herself, more depressed and more anxious. When she was depressed, she would go drinking and partying with friends. When she was anxious, she would use illegal drugs that would help “calm [her] nerves.” Becky explained why she did not initially seek mental health services. “I told God that he needed to heal me.” “I didn’t need no doctor putting me in a mental institution.” She described her life as a “battle field for five more years.’’ Getting through each day and raising her daughter was difficult, but she said: “I depended on God and he held my hand through it all every day.” Becky eventually had a breakdown after which she thought she would “be locked in a mental institution”, and her “daughter would be taken away.” But said she kept praying while admitted in a hospital and said to God: “If you let them send me home, I’ll serve you forever.” When she was discharged and sent home “only with anti-depressants”, she knew it was a miracle and that she had indeed been healed. Even though Becky was still on anti-depressants, she said she did not consider herself to have depression or anxiety, and was only taking medications because they reminded her of the day she got discharged from the hospital “the day God spared her from shame.”

Because of the shame and blame associated with mental health problems, contact with mental health providers and use of mental health services including taking medications are stigmatizing in ULH. One woman who had just recently started taking antipsychotic

medications said that even though medications might be helpful, she felt that taking medications demonstrated a lack of faith in God and a "weakness of the mind". When asked if she felt the same way about taking medications for other problems such as headaches, or more serious physical illnesses like diabetes, she smiled and responded that: "but everyone knows that people have illness like that and they have medication that works." "For emotional problems, it seems like girl, you better be able to handle yourself. It is disappointing… to you and even your peeps if you can't", she explained. As shown, shame, guilt, and stigma seemed to be exacerbated among religious persons because mental health problems were sometimes believed to reflect failure in their relationship with God or might lead others to question their religiosity.

In ULH, mental health problems were associated with weakness, failure, shame, and emotional instability, and people with mental disorders were thought of as unreliable. Some residents may conceal their experiences or symptoms of mental health problems because acknowledging any possible symptoms of disorders suggests that one is incapable of fulfilling their responsibilities to the community. Consequently, mental disorders are not frequently expressed in ways that might reflect personal weakness. And sometimes, people would consciously engage in behaviors that mask symptoms of specific disorders such as depression. The shame and guilt associated with mental health problems also delayed or prevented some individuals from seeking treatment.

Expressions of depression

Depression was expressed and recognized through a wide variety of symptoms, some of which were metaphors, and others internalizing and externalizing behaviors. Depressive

emotions were encoded in feelings, behaviors, physical experiences, and in social contexts. Takesha, for example, described her experience of depression as feelings of heaviness. I tried to get her to go with me to a community event in celebration of the life and birthday of a child who had been randomly shot and killed over 3 years ago. Takesha refused to accompany me to the gathering because it would make her "depressed", and because she "can't deal with shit like that, people all choked up and stuff." I took the opportunity to ask Takesha, directly, how depression was for her. Her experiences were that she would be so unmotivated about life that "instead of trying my best, I just say fuck it. What's the point?" Other expressions of depression for Takesha included "having a heavy heart" and "a weight in my mind that I can't seem to shake."

Internalizing behaviors and emotions such as social isolation, guilt, and feelings of worthlessness were other ways of expressing depression as exemplified by Camilla. Camilla's friend Jenney was familiar with my work, and had asked Camilla to talk to me about her condition – she had recently been diagnosed with depression. I proceeded to ask Camilla how she felt about her diagnosis, and whether she believed that she had depression. She hesitated and then responded: "Maybe I do, I mean I don't know but I'm surprised because we don't have like depression and stuff in my family." I inquired why she had decided to go to the doctor. Camilla had gone because her boyfriend's mother who was a social worker at the health center had insisted that she had to, and had helped with securing the appointment. Camilla explained that she had lost the desire to hang out with family and to have fun. She would stay in her bedroom most days, and had difficultly interacting with her children. She acted like everything was okay when her children were around. When I asked her why she had to act as if everything was okay,

she said: “Cos I had to be. I mean, I know I’m strong but I could NOT keep it up. Was like a heavy cloud was covering my being.” Jenney added that her friend was feeling guilty of not being a good friend, and a good mother, and had lost all her energy. Camilla shared other symptoms that she experienced- she could neither eat nor sleep, and had finally lost some weight but then felt worthless and unattractive.

Camilla had “felt like shit” for over two years before her boyfriend’s mother noticed that she might have some mental health problems. According to Camilla, people just thought that she was being “a moody hormonal bitch” or was having problems with her boyfriend or with the father of her children. Despite potential sources of stress in her life such as working stressful jobs in the fast food industry, raising a child with special needs, and having an unemployed boyfriend who would not help with childcare and other domestic labor, Camilla believed that her depression was only caused by hormonal imbalances. She thought of herself as being “well capable of handling things” because she had “done it successfully for years.” However Camilla explained that she was now willing to add medications for depression among things she will try at least once in life.

Shannon also expressed depression through internalizing behaviors, and as a chain smoker, she believed that “Nicotine is a antidepressant.” When asked about how she experienced depression, Shannon had a hard time articulating her experiences. After taking some time to think about it, she responded that depression was “feeling like all hope was gone,” and “not wanting to go out and have a life.” She would not know what to do next, and felt stuck even after exhausting all possibilities. She talked about losing

hope for a better life, and the inability to do things with her son, her church, friends and family.

Others expressed depression through a combination of externalizing and internalizing behaviors. Bettina, a middle age school teacher, explained her experiences of depression as the times when her mind and body would shut down and she would simultaneously become agitated. “I can’t get going….work or church, and I become very agitated if someone says hey sis, are you doing okay?” Several months later, after seeing a doctor and taking medication, Bettina described her latest bout of depression as “uncontrollable anger and just being super emotional. Everything was so overwhelming.” It was hard for her to understand why she was experiencing these symptoms because she felt like she had all she needed in life. “I don't have to work or worry about money. Everyone thinks I have a perfect life and I don't know how my life could be any better materially.” Bettina continued: “even with a beautiful home, a wonderful son, and a stable job, I was just so miserable, couldn’t function. I cried over stupid stuff and everything pissed me off, I wanted to kill anyone in my way half the time.”

Other expressions of depression common in ULH included excessively socializing with family and friends, anger, aggression, and violent behavior. Pastor Jones, a well- known minister and community leader expanded on these indicators of depression by gender. When we met for breakfast, I asked what mental health looked like in his community. As he counseled people over the years, Pastor Jones had noticed that among women, depression was present when they were isolating themselves and not showing up when they had to. He believed that depression had set in when a person became afraid to be on

their own, and constantly wanted to be with friends or family. “There has to be some balance between the time they devote to being with others and their personal time.” “Lack of balance between family time and private time- you’ve got to think something is wrong psychologically”, he continued.

Drawing from his personal experiences and from those of his congregants, Pastor Jones explained that depression looked like: “rage, anger, agitation and dangerous behavior that lacks consideration for others.” He often worried about the possibility of depression when Black men begin “suicide by cop behavior” – deliberately behaving in a way such as to provoke a harmful response from an armed police officer. Pastor Jones elaborated that most forms of “irrational, violent behavior and criminal acts” by Black men were signs of underlying /untreated depression. “They lose hope and the only way to get back at the world is to act out.” According to Pastor Jones, a common issue in the Black community is that “mental illness is seen as a weakness. Being aggressive, numbing it out, and engaging in anti-social behavior is a way to stop others and yourself from seeing that you’re vulnerable.”

Because aggression also emerged as a response to stress, I asked key contacts to help clarify contingencies of aggression as a stress response and as an expression of depression. Aggression was considered a way of expressing depression when aggressive behavior was intentionally directed towards a person of authority. When behavior was directed towards friends, family, and persons in an individual’s network, key contacts considered such behavior to be a response to stressful circumstances. Therefore the context within which aggression occurs may qualify it either as a response to stress, an

outcome of stress, or an expression of depression. Similarly, the context of excessive socialization determined whether it was a stress response or an expression of depression (outcome of stress). Excessive socialization was considered a stress response when employed to affirm identity and to secure social support. However, it was an indicator of depression when the purpose was to prove to others that one was still doing well, was not weak, and still had it together.

Martha articulated how excessive socialization was employed by her best friend who she described as having "psychological problems." "The way she be everywhere chilling, partying, and who knows what else out there. She's trying to hide the problem but she don't know that all her hommies knows." Martha was familiar with socialization as one way of expressing depression from her experiences with her mother. "When my ma was everywhere doing this here and that there, meeting up with everyone she knows in two days, we were all like waiting for her to crash and show the crazy." "Is like with [Danette], they both was scared to just sit back and deal with the depression", she said. Martha's opinions regarding her mother and her best friend supported Pastor Jone's point that some women with depression rarely wanted to be by themselves, and that the need to constantly be with friends and family is in and of itself an expression of depression. Although it is hard to differentiate when one is socializing as stress management from when that socialization is an indicator of depression, excessive socialization can mask typical symptoms of depression in the DSM such as isolation and sadness, and can conceal classic outcomes of depressive disorders such as impairment of social functioning.

Cultural model of depression

CCA was employed to identify a cultural model of depression in ULH. As with the case of stressors, and stress responses and resources, residents of ULH perceived to be age 18 and older were approached at different locations in the community and were asked to list the things that would indicate depression, or that have been used to describe people who have had depression. Again, each participant was selected to ensure maximum variation in the sample in terms of gender, age, and perceived socio-economic status. A total of 38 residents responded to this question, and 21 responses were listed by at least 10 percent of the respondents. These responses and their frequencies are shown on Table 7.1

Extreme sadness, low self-esteem, hopelessness, having a heavy heart, and lack of motivation were listed by more than a third of persons who participated in the free-listing exercise for expressions of depression. The final universe of depression indicators - expressions and symptoms - consisted of 24 items. Three additional items: not dependable, excessively socializing, and loss of appetite were included on the list because they emerged as characteristics of depression in the ethnography although they did not make the 10 % frequency minimum in the free-listing exercise.

Forty key informants rated how common each item was as an indicator of depression among African Americans in ULH. Each item was rated as not common (1), somewhat common (2), or very common (3). Table 7.2 summarizes these ratings. Indicators of depression that were most frequently rated as very common among African Americans in ULH included extreme sadness (85%), having a heavy heart (69.2%), low self-esteem (67.5%), self-isolation (65%), lack of motivation (62.5%), and hopelessness (60%).

Table 7.1 Expressions of depression listed by respondents (# of Participants = 38)		
Expression of depression	**# of participants listing item**	**% of participants listing item**
Extreme sadness	18	47.3
Low self-esteem	16	42.1
Hopelessness	15	39.4
Having a heavy heart	13	34.2
Lack of motivation/interest	13	34.2
Weakness/having a weak mind	12	31.5
Not knowing what to do next	11	28.9
Agitation	10	26.3
A weight on the mind that won't shake	10	26.3
Self-isolation	10	26.3
Moody	8	21.0
Irrational, dangerous and violent behavior	7	18.4
Sleeplessness	7	18.4
Having the blues	7	18.4
Rage and anger	7	18.4
Over eating	6	15.7
Paranoia	5	13.1
Crying	5	13.1
Bad nerves	5	13.1
Heavy feeling in legs	5	13.1
Sleeping too much	4	10.5

CCA was employed to assess whether the rating patterns on Table 7.2 were due to individual respondents drawing from the same cultural knowledge of depression. Results from CCA helped determine whether the level of agreement regarding depression among key informants was sufficient to assume that the indicators of depression rated as common are culturally salient, or that there is a cultural model of depression in ULH.

Table 7.2 Prevalence of expressions of depression						
Symptoms/Expressions	**Not Common**		**Somewhat Common**		**Very Common**	
	%	**(n)**	**%**	**(n)**	**%**	**(n)**
Extreme sadness	0.0	(0)	15.0	(6)	85.0	(34)
Having a heavy heart	5.0	(2)	27.5	(11)	67.5	(27)
Low self-esteem	2.5	(1)	30.0	(12)	67.5	(27)
Self-isolation	2.5	(1)	32.5	(13)	65.0	(26)
Lack of motivation/interest	0.0	(0)	37.5	(15)	62.5	(25)
Hopelessness	2.5	(1)	37.5	(15)	60.0	(24)
Not knowing what to do next	5.0	(2)	40.0	(16)	55.0	(22)
Agitation	10.0	(4)	35.0	(14)	55.0	(22)
Irrational, dangerous and violent behavior	7.5	(3)	40.0	(16)	52.5	(21)
Weakness/having a weak mind	10.0	(4)	37.5	(15)	52.5	(21)
A weight on the mind that won't shake	10.0	(4)	37.5	(15)	52.5	(21)
Crying	12.5	(5)	35.5	(15)	50.0	(20)
Sleeplessness	27.5	(11)	25.0	(10)	47.5	(19)
Overeating	12.5	(5)	42.5	(17)	45.0	(18)
Rage and anger	17.5	(7)	37.5	(15)	45.0	(18)
Have the blues	10.0	(4)	47.5	(19)	42.5	(17)
Moody	47.5	(19)	10.0	(4)	42.5	(17)
Not dependable	40.0	(16)	40.0	(16)	40.0	(16)
Sleeping too much	20.0	(8)	42.5	(17)	37.5	(15)
Loss of appetite	27.5	(11)	40.0	(16)	32.5	(13)
Paranoia	10.0	(4)	57.5	(23)	32.5	(13)
Excessively socializing	52.5	(21)	17.5	(7)	30.0	(12)
Heaving feeling in legs	52.5	(21)	22.5	(9)	25.0	(10)
Bad nerves	55.0	(22)	20.0	(8)	25.0	(10)

Following CCA methodology, factor analysis of informants using the iterated principal factor algorithm, without rotation, was performed. The eigenvalue for the first factor was 23.07 and for the second factor, it was 4.23. This indicates a ratio of 5.45:1, clearly exceeding the 3:1 threshold required for a single dominant factor (Table 7.3). These results, according to consensus analysis, demonstrate that key informants are drawing from a shared belief system about depression.

Table 7.3 Factor analysis of informants for indicators of depression		
Factor	**Eigenvalue**	**Proportion of variance**
1	23.07985	0.8766
2	4.23685	0.9008
3	0.18062	0.0115
Ratio of 1st to 2nd Eigenvalue 5.45:1		

Items that constitute this cultural model of depression were identified from the universe of indicators of depression in ULH. Since the factor analysis was of individuals, the factor loadings (Appendix D, Table D3) for each individual informant represented their correlation with the shared cultural model of depression. To determine the components of this model, the individual key informant factor loadings were used to weight the responses of each informant in the survey. Weighted informant significance scores for each indicator were calculated and averaged to create a cultural 'answer key' or *truth* for the sample of key informants. Expressions or symptoms of depression that had a weighted average score of above 2 (somewhat common) were considered to be part of the cultural model of depression. Table 7.4 indicates the weighted average rankings for indicators of depression.

As shown, indicators with the most cultural significance such as extreme sadness, lack of motivation, having a heavy heart, low self-esteem, self-isolation, and feeling hopeless

were also most frequently rated in the survey as very common, and emerged during informal conversational interviews in the course of the ethnography.

Table 7.4 Weighted average significance score for expressions of depression	
Expressions and Symptoms	**Weighted Average Score**
Extreme sadness	2.65
Having a heavy heart	2.55
Lack of motivation/interest	2.50
Hopelessness	2.45
Low self-esteem	2.43
Self-isolation	2.40
Weakness/ having a weak mind	2.38
Crying	2.35
Not knowing what to do next	2.33
A weight on the mind that won't shake	2.28
Agitation	2.25
Loss of appetite	2.23
Irrational, dangerous and violent behavior	2.22
Have the blues	2.20
Sleeping too much	2.18
Rage and anger	2.17
Not dependable	2.16
Sleeplessness	2.15
Paranoia	2.05
Over eating	1.90
Moody	1.85
Excessively socializing	1.83
Bad nerves	1.75
Heaving feeling in legs	1.70

Some of these indicators are consistent with classic DSM-V symptoms of major depressive disorder. These include lack of interest, sadness, low self-esteem, agitation, sleeping too much or not being able to sleep, and loss of appetite. However, other salient components of the cultural model of depression in ULH such as a having a weak mind,

paranoia, anger, and irrational behavior are not listed as symptoms of major depressive disorder in the DSM.

The objectives of this chapter were to describe how Black residents in ULH conceptualized mental health problems and to identify common indicators of depression. Findings from the ethnography and CCA show that ULH residents conceptualized mental illnesses as weakness, and associated mental health problems to difficulties in performing expected roles. Stigma was associated with mental health problems and with depression, in particular. Indicators and expressions of depression in ULH ranged from internalizing behaviors such as extreme sadness and hopelessness to externalizing behaviors such as violence and aggression.

CHAPTER 8

DISCUSSION, IMPLICATIONS, AND CONCLUSION

The goal of this study was to describe how culture shaped the stress process among African Americans living in urban poverty. I assessed whether culture influenced the three main components of the stress process – stressors, resources, and mental health problems (outcomes of stress) among Blacks in ULH. Three specific objectives were addressed: 1) To describe culturally salient sources and characteristics of stress, 2) To identify culturally salient stress-buffering resources and responses to stress, and 3) To identify shared definitions and expressions of mental health problems. The results demonstrate the presence of distinct stressors, stress experiences and meanings in ULH. The race paradox in mental health – findings of similar or lower rates of common mental disorders among Blacks compared to Whites in epidemiological studies can be explained by the presence unique stress responses and ways of expressing mental health problems that are tied to the cultural contexts within which African Americans live.

8.1 Unique stressors in ULH

Racism and socio-economic disadvantage are the main sources of vulnerability to poor mental health among African Americans (Hudson et al. 2012; Williams et al. 1997; Williams and Williams-Morris 2000). While these have explained poor physical health outcomes among African Americans compared to Whites, African Americans still have similar or better mental health than Whites. In most of the research that assesses racial differences in the prevalence of common mental disorders, standard indicators of disadvantage such as poverty, low educational achievement, and unemployment are

expected to lead to poorer mental health outcomes for Blacks compared to Whites (Harris et al., 2005; Roxburgh 2009; Bratter and Eschbach 2005; Dunlop et al., 2003). While this work demonstrates that these indicators, as well as racism, are a part of the cultural model of stressors among African Americans in ULH, several other stressors were of higher significance. For example, gun violence, role strain, police, incarcerations, poor housing conditions, and grief from the death of loved ones are significant stressors in ULH whose effects on mental health outcomes across race have not been vigorously explored.

Stressful life events, chronic strains and daily hassles are presumed to be objective stressors in the mental health literature. As such, stressors have traditionally been assessed using stressful event checklists and interview measures of life events, chronic stress and daily hassles as deemed relevant by the researcher. On the one hand, checklists are assumed to represent stressful life events that occur within the population under study (Caspi, Bolger, and Eckenrode 1987; Dohrenwend and Dohrenwend 1982; Dohrenwend 2006; Turner and Wheaton 1995). However, these checklists are neither exhaustive nor representative of the universe of stressful events experienced by a population. On the other hand, interview measures get at more individual and contextual characteristics of events; respondents are able to identify the most stressful events in relation to other events (Dohrenwend et al. 1993; Dohrenwend 2006). These interview measures have however been criticized because the amount of contextual information that is elicited confounds the assessment of stress. Specifically, it is unclear whether the measure of stress results from the magnitude or severity of an event or from an individual's social vulnerability to the stressor (Dohrenwend et al. 1993; Wethington, Brown, and Kessler 1995). Findings from this study demonstrate that both the severity of a stressful event and

the social vulnerability to an objective stressor are influenced by cultural and contextual factors. These factors shape how an event is appraised to be stressful and the degree to which a stressor is perceived as threatening, demonstrating that salient stressors are socially constructed.

Social construction of stressors: Social constructionism emphasizes that phenomena are neither exclusively natural nor have intrinsic meanings. Rather, meanings are developed through interaction and are shaped by social and cultural systems (Collins 1994). Applying the social construction framework, events will become stressful to individuals and groups based on ascribed meanings that are distinct from the nature of the stressor, and that are not assumed to be implicitly associated with the stressor. Objective and inherent sources of stress, although important, are limited in their ability to cause or produce stress. Stress is not implicit in major life events, or in phenomena qualified a priori as chronic strains and daily hassles. Stress-producing characteristics of events and phenomena are conferred within specific cultural contexts and processes.

For Blacks in ULH, social comparison was one of these processes. The fundamental principle of social comparison is that people will evaluate their opinions and abilities by comparing them with similar others (Festinger 1954; Wood 1996). Therefore much of people's understandings of themselves and their circumstances are not free of context, but are placed in reference to salient others in their lives. How salient others or reference groups are selected is under debate and varies with the particular opinion, value or ability in question. While some reference categories are selected to allow for self-enhancement

(Collins 1996), others are chosen simply for the purpose of evaluating one's own standing (Wood 1989; Wood 1996).

Regardless of the purpose of social comparison, groups tend to select salient groups with similar values as the reference group (Peng, Nisbett, and Wong 1997). Consequently, comparison groups for Blacks in ULH were other African Americans in the community, as well as family members or friends who share the same ideals but live in other cities. This partially explains why objective sources of stress such as poverty and unemployment were not considered significant stressors in individual informal conversations during the ethnography. Most of my key contacts and their friends compared their employment statuses with others in their close networks. Even though most were unemployed or precariously employed, unemployment was not perceived to be significantly stressful. This was due, in part, to social comparison with the purpose of enhancing one's own position in comparison to salient others. In his study of circumstances, experiences and aspirations of Black men living in urban poverty in Chicago, Young (2004) found that those whose daily interactions were limited to their immediate communities (across race and class lines) evaluated themselves in comparison with their peers and believed that their individual attitudes and hard work would lead to success. Consistent with his finding, Black men in ULH compared themselves with other individuals they knew, and perceived their personal circumstances to be better than salient others in their lives. Therefore on an individual level, employment was not a stressor if one felt that they were doing better in some way than others in their networks.

Interestingly, CCA showed that unemployment and poverty were components of the cultural model of stressors in ULH. Data for CCA was elicited to reflect the community of African Americans living in ULH. It is likely that because participants were asked about things that cause stress among their community and to rate the significance of stressors for the community (as opposed to personal experiences),the reference category was not chosen for self or personal enhancement, but to evaluate how African Americans fared as a group. In most studies on relative deprivation, members of disadvantaged social groups are evaluated in comparison to more privileged groups - upward comparison (Åberg Yngwe et al. 2003; Kondo et al. 2008; Pham-Kanter 2009; Wood 1996). One study among college students in California illustrates how perceptions of deprivation differ at the group and individual levels. Tropp and Wright (1999) found that American Americans were likely to report higher rates of group deprivation when in comparison to other groups, and a lower sense of personal deprivation when personal level comparisons were made. The authors suggested that the history of discrimination against African Americans as a group in the U.S., and the collective knowledge about this discrimination influence how Blacks rate experiences of the Black population compared to other groups (Tropp and Wright 1999). Social comparison and reference categories therefore shape the construction of stressors in ULH.

In their early work that explores coping processes, Pearlin and Schooler (1978) present positive comparison as a mechanism for coping. When positive comparisons are employed, the effects of events are mitigated as individuals assess their conditions to be better or at least similar to those of significant others. Negative impacts of stress are also mitigated when individuals construe their present circumstances as an improvement of

previous conditions (Pearlin and Schooler 1978). Because of its conceptualization as a coping mechanism, social comparison has been assessed as a resource in the stress process – modifying the effects of neighborhood disadvantage on anger among older adults and on subjective assessments of neighborhood problems such as substance use and street loitering (Schieman and Pearlin 2006; Schieman, Pearlin, and Meersman 2006).Therefore it is possible that in addition to being a social process through which stressors are constructed in ULH, social comparison might also be perceived as a coping mechanism; a resource to deal with stress. I found social comparison to be a lens or frame within which stress is constructed because the recognition that a situation or condition is a stressor preceded the mobilization of mechanisms and resources to alleviate its effects.

Another cultural process that shapes the appraisal of stressors is expectations around social mobility. Findings from the current study suggest limited expectations of upward mobility and the experience of significant adverse events earlier in the life course of Blacks in ULH. Because of frequent exposure to such events, subsequent noxious events are not perceived as threatening, or considered salient stressors as they would by those with no previous exposure to adverse events or by persons who are not socialized to expect them. Again, using unemployment as an example, this objective stressor was not considered salient by individuals possibly because it was expected and was not often considered a reflection of personal failure. The meaning of unemployment in ULH was immersed in the notion that achievements and aspirations are made possible by what individuals perceive as probable, possible and desirable within the surrounding social structure (MacLeod 1987). It can then be inferred that stress that results from unfulfilled aspirations, and from failure to achieve social mobility are salient only to the extent that

residents of ULH believed or expected these aspirations to be possible and successes attainable.

Social comparison and expectations regarding social mobility affect meanings and appraisals of events that are considered to be objectively stressful in the literature. Yet, in studies where stressors are implied from socioeconomic disadvantage or assessed using checklists and interviews, the roles of social comparison and social expectations are not accounted for.

8.2 Stress Responses and Resources

One of the most common responses to stress in ULH was impression management. The concept of impression management stems from broader sociological theory that explains self-assessment through human interaction. Positive assessment is important because individuals learn about themselves in relation to others. Cooley (1902) proposed the looking glass self and argued that each self consisted of three main elements: 1) the perception of how one appeared to the other, 2) the perception of the other's judgment of that appearance, and 3) one's own feelings towards that appearance – predominantly around pride or shame. According to the looking-glass self, social relationships and interactions give birth to the self and its components (Cooley 1902). Impression management expands the concept of the looking- glass self by asserting that individuals are invested in presenting positive appearances to avoid negative evaluations of the self (Goffman 1967; Scheff 2005). These negative evaluations or shame can lead to withdrawal, violence, and emotional dysfunction via recursive loops as the self is

constructed and reconstructed in social interaction (Scheff 2013). Individuals are always trying to actively avoid shame by impression management.

In *The Presentation of Self in Everyday Life,* Goffman (1959) drew attention to the ways by which individuals presented themselves in different settings. Social life consists of two main stages, the front and the back stage. According to Goffman, individuals are always performing. At the front stage, individuals present their formal selves to an audience who do not have access to the back stage. At the back stage, actors may express informal or even counter-formal selves (presenting oneself in a manner that is in direct contrast to how one presents themselves in public). Activities at both stages are symbiotic in that actors can review and prepare for front stage activities at the back stage (Goffman 1959).

Impression management happens more consciously at the front stage. In ULH, the interaction of residents with clinicians, persons in position of power such as pastors, community leaders, White people, researchers, or interactions in public or professional settings are front stage performances. The back stage in ULH would include contexts in which residents can be themselves. Goffman (1959) asserted that the backstage consisted of spaces out of view to the public, and where actors could express beliefs or actions that are not permitted or sanctioned in the front stage. Therefore backstage performances in ULH would range from conversations and meaning making around issues such as racism, sharing ways of dealing with stress, to simply just blowing off steam or taking a break from emotionally taxing roles in the front stage.

I argue that impression management as a stress response is tied to the experiences of anti-Black racism, a stressor considerably unique to African Americans. Race is a social category that is associated with both crediting and discrediting attributes. Race influences the opinions that people form about others as well as negative perceptions about Blacks in the United States (Feagin 1991; Howarth 2006). Blacks in ULH invoke impression management to alter and influence how they are perceived. Burke (1991) argues that social distress results from the disconnect between how an individual wants to be perceived and how people actually perceive them. If an individual's view of their identity in a given context is inconsistent with input or feedback from others, distress results. In an attempt to prevent or resolve this distress, individuals try to alter how people perceive them such that the perceptions of others match with how they want to be perceived (Burke 1991). The process of negotiating and matching identity is a strategy for impression management common among African Americans who constantly deal with discrediting racial attributes and stereotypes. Most people employ impression management to enhance their image or to create a favorable social outcome. Because of racism, African Americans are likely to actively present themselves in ways that counter racial stereotypes. In ULH, impression management was a direct response to racism and residents were invested in presenting a favorable public image that might lead others to form more positive judgements about them.

Employing impression management may also mean that African Americans in ULH are in denial that their objective circumstances are stressful. Denial is both a strategy and an outcome of impression management, especially where the goal is to discredit stereotypes (von Hippel et al. 2005). Hippel and colleagues argue that the "integrity of the self can be

maintained either by denying the accuracy of the stereotype (a collective strategy) or by denying its self-relevance (an individualistic strategy)" p. 23.They conducted a series of experiments to test the relationships between denial, employment of impression management, competence and intelligence among African Americans. Findings demonstrated that persons who were concerned with how they were perceived were more likely to deny incompetence and claim intelligence compared to persons who did not care about their image. Hippel et al. (2005) also found that denial was more likely to be employed as an impression management strategy when the audience/experimenter was White.

However, Goffman (1959, 1967) did not claim that when individuals manipulated their public displays, they were in denial about their informal or backstage identities. He stated that "when one's activity occurs in the presence of other persons, some aspects of the activity are expressively accentuated, and other aspects which might discredit the fostered impression are suppressed." (1959:111). Goffman's claim was that what people might conceal during impression management varied by context. I can neither draw from the concept of impression management nor infer based on my analysis that key contacts in ULH who employed impression management might have denied that certain experiences or events were stressful because I did not assess the authenticity of the presented self in all circumstances. However, if there was "unobserved" denial, this denial would serve to distract immediate focus from the stressors and could be perceived to protect the individual and collective image of African Americans in ULH.

The finding that religion is a stress resource is consistent with existing literature. Religious coping is a significant way of dealing with stress and illness among African Americans (Marks et al. 2005; Shorter-Gooden 2004), and is associated with lower rates of distress (Chapman and Steger 2010). As described in the findings, African Americans in ULH share the belief in a higher power that controls the circumstances of their lives, and that surrendering to such a power is the best recourse. This belief is associated with better mental health (Parker et al. 2003), and lower rates of psychological distress among Blacks compared to Whites (Schieman et al. 2006). In a qualitative analysis that identified ways by which African American women used religion to cope and make meaning from adversity: complete surrender to a higher power and letting go were significant but passive forms of coping that provided a means to transcend negative psychological effects of adversity (Mattis 2002). In an earlier study, McAuley et al. (2000) investigated differences in the perceived relationship between God and health among African Americans and Whites in rural Oklahoma. McAuley and colleagues found that African Americans were more likely to spontaneously make references to the role of God in their health whereas Whites even when directly asked, were likely to respond in the negative or were uncertain. In addition, African Americans perceived God as a comforter who ameliorated the effects of illness by making it easier to accept and deal with illness, and to continue physical and emotional functioning. While African Americans saw illness as a test of faith, a call to action, and to bring them closer to God, Whites did not mention closeness to God as a function of illness (McAuley, Pecchioni, and Grant 2000). For some African Americans, responding to stress does not entail

focusing on the degree to which the stressor is threatening, but on the greater spiritual purpose that it serves.

In ULH, perceived social support was afforded by the knowledge that others were praying for one. This source of support was a significant resource to deal with stress in ULH. Findings from a longitudinal survey of older adults show that the belief that other people are praying for one buffers some of the negative effects of poor neighborhood conditions on depressive symptoms (Krause 2006). The level of social support afforded through religion is likely to be heightened in the Black community in ULH, and among African Americans in general because of the strong role that the church plays in the lives of African Americans in providing ways of dealing with problems that result from the social location of Blacks in the United States (Barnes 2005; Holt et al. 2013; Taylor, Chatters, and Jackson 2007). Indeed, findings from a recent study demonstrate that a high religious commitment mediates the relationship between racial identity, well-being, and meaning in life among a sample of African Americans in the U.S. (Ajibade et al. 2015) (Ajibade et al. 2015).

John Henryism (J.H.) conceptualized as a cultural means of coping among African Americans was common in ULH. Even though there was a lack of economic resources, some residents were vigorously committed to working hard, staying positive, and continuously engaging both mental and physical labor without any objective signs of a positive outcome. Although several studies have found this means of coping to be common for stressors such as racial discrimination - also a salient stressor in ULH, research that has explored its association with mental health outcomes and the mediation

effects of J.H. in the relationships between stressors and mental health outcomes are limited and contradictory. For example, one study of African American men in Southern and Western cities in the U.S. found that J. H. was associated with lower depressive symptoms, and that J.H. reduced the effects of racial discrimination on depressive symptoms (Matthews et al. 2013). Another study of Black women in Midwestern U.S. cities also demonstrated a negative association between J.H. and psychological distress (Bronder et al. 2014). Findings from these two studies are in sharp contrast with those based on nationally representative data from the NSAL where there was a positive association between depression and J.H., and no effects of J.H. on the relationship between discrimination and depression (Hudson et al. 2015). How these relationships will play out in ULH and in other Black communities across the U.S. remains to be investigated.

Joining street gangs was a salient response to stress in the ethnography. Payne (2001) argues that street life is a "site of resiliency" especially for poor Black men. Although street life stems from economic and social forces that limit the life chances of Black men, the street serves as a physical and psychological space within which strength and resilience are produced (Payne 2001). This was true for some key contacts who had been members of gangs in ULH. Violence and gang membership, although stressors themselves, are means of coping with economic and psychological strain (Messner and Rosenfeld 2012). Joining a gang is a behavioral response perceived to protect an individual from any psychological harm caused by social or economic circumstances, and to accentuate identity, values and beliefs (Alleyne and Wood 2010; O'Brien et al. 2013; Shap 2014).

Surprisingly, gang membership and substance use, although salient responses in the ethnography, were not sufficiently significant in CCA to be part of the cultural model of stress responses and resources in ULH. The reasons for this incongruence are unclear. Given that gun violence, robberies, the presence of drug dealers and homicide were significant stressors from the CCA and can be directly linked to gang membership and substance use, one potential reason for the incongruence in stress responses might be impression management; an attempt to protect both individual and community reputation. Whereas stressors can be deemed as more external factors, responses to stress can easily be perceived as the direct responsibility of an individual or a community. It might therefore have been easier for respondents to rate the presence of drug dealers, for example, as a significant stressor and at the same time, unlikely to rate drug use as a response to stress. Of course, this explanation is speculative at best and warrants further investigation.

8.3 Cultural meanings and expressions of mental health problems

The perception of mental disorders as a sign of weakness, as well as silence and stigma attached to mental health problems were prevalent in ULH. These findings provide support for the postulation that compared to White communities, members of Black communities are more likely to perceive mental disorders as a weakness in character. Several studies have found that mental illnesses are more stigmatizing in Black communities (Schnittker 2003; Silva de Crane 1981; Thompson, Bazile, and Akbar 2004). For example, in a qualitative study of psychotherapy among African Americans, focus group participants reiterated that the African American dream is to be considered a strong family and that mental illnesses are not consistent with being strong. Participants felt that

because mental illnesses are considered a sign of weakness, most strong families would not recognize them as such in the first place (Thompson, Bazile, and Akbar 2004). Biographic accounts of mental illness experiences among African Americans suggest that some members of the community perceive mental illnesses to be signs of weakness (Danquah 1998; Thompson, Bazile, and Akbar 2004). These sentiments and perceptions are consistent with findings in ULH where people with mental health problems were thought of as being mentally and psychologically weak, and unreliable. Not surprisingly, findings from CCA showed that having a weak mind and not being dependable were culturally significant indicators of depression.

Findings about stigmatizing attitudes regarding mental health from quantitative studies that compare Blacks to Whites vary. While some suggest that there is similar or lower likelihood of stigmatizing attitudes towards mental health problems among Blacks compared to Whites (Anglin, Link, and Phelan 2006; Brown et al. 2010; Diala et al. 2001; Givens et al. 2007; Jimenez et al. 2013), others document higher stigmatizing attitudes among Blacks (Alang 2015; Conner et al. 2010; Rao, Feinglass, and Corrigan 2007).This might reflect differences in measures of stigma and stigmatizing attitudes, and in the samples - general population versus persons with mental health problems, and local versus nationally representative samples. The current study demonstrates the presence of stigmatizing attitudes (such as shame, association with weakness, and inability to handle problems) towards mental health problems among Blacks in ULH but makes no claim regarding whether these attitudes differ among Whites in the same neighborhood.

Research on idioms and expressions of distress among African Americans is limited. Heurtin-Roberts, Snowden, and Miller (1997) reviewed symptoms of anxiety from ethnographic studies of African Americans and compared them with symptoms of anxiety reported in the ECA data. They found several symptoms from the ethnography that were not in ECA data. Their findings also suggested that African Americans had several somatic symptoms of anxiety. Other researchers have also argued that there are high rates of somatization of mental and emotional disorders among African Americans (Jones-Webb and Snowden 1993; Robins and Regier 1991; Snowden 1999). However, in the current study, none of the symptoms that constituted the cultural model of depression in ULH can be described as somatic. This might reflect differences in various mental disorders such as between depression and anxiety, and heterogeneity among African Americans in the U.S.

In a qualitative study of church-based depression interventions among African Americans, ministers of one of the largest Black churches in the U.S. defined depression as a feeling of being hopeless, helpless, and trapped (Hankerson et al. 2013). This is consistent with items such as hopelessness and not knowing what to do next, that are part of the cultural model of depression in ULH. Most studies that have explored indicators of depression among African Americans have been in clinical settings among patients seeking or receiving mental or physical health services. For example, among patients receiving psychotherapy, African Americans were significantly more likely to report symptoms such as sleeplessness and loss of appetite than Whites (Ayalon and Young 2003). Earlier research also found agitation, aggression, hostility and paranoia to be associated with depression among African American patients in clinical settings (Adebimpe et al. 1982;

Fabrega, Mezzich, and Ulrich 1988; Whaley 1998).These findings are consistent with the current study given that the above symptoms are a part of the cultural model of depression in ULH.

8.4 Proposed cultural explanations for the race paradox in mental health

Two main explanations for the race paradox in mental health emerged from this study. First, impression management is a culturally salient response to stress that may cause African Americans to hesitate or simply not acknowledge symptoms of common mental health disorders in epidemiological surveys. Impression management is tied to the context within which stress occurs in the lives of African Americans and to shared perceptions of mental health problems among Blacks. For example, because of racism, African Americans are more likely than Whites to worry about how they are perceived in the society. The shared understanding that society holds discrediting views about Blacks causes African Americans to employ impression management when interacting with others so as to minimize or counter discrediting stereotypes. Racism and racial stereotypes are stressors that also constitute the context within which Blacks live. Racism makes impression management a more exigent stress response for African Americans. Impression management provides a way of dealing with stress but also masks stress outcomes and influences whether stress and its consequences are acknowledged.

I argue that impression management is particularly intensified when completing surveys or answering questions that assess mental health. Breslau and his colleagues (2008) demonstrated that non-Hispanic Blacks were less likely than their White counterparts to respond positively to questions that asked whether they experienced a lacked of energy,

felt worthless, or had thoughts of suicide. As demonstrated in this study, there are negative connotations about depression and mental health problems in general among African Americans. People with mental health problems are perceived as weak, and mental disorders are discrediting within the community. For these reasons, when completing epidemiological surveys that assess mental, psychological or emotional problems, African Americans would be less likely to acknowledge or report any symptoms they may experience.

Second, there are different ways of expressing depression that are not captured by instruments used in epidemiological surveys. Even though some indicators of depression that constitute the cultural model of depression are classic symptoms that are operationalized in survey instruments like the Diagnostic Interview Schedule or the Composite International Diagnostic Interview, several expressions of depression in ULH are not on the commonly used instruments. These expressions include having a weak mind, paranoia, rage, anger, violent behavior, and not being dependable. I argue that researchers are missing these symptoms in their measures for depression (and possibly for other common mental disorders). Existing measurement instruments fail to capture certain culturally salient expressions of distress, leading to low prevalence estimates. Therefore existing estimates might not truly representative of depression and other common mental disorders as they are understood and expressed among Blacks

8.5 Study Limitations

While some scholars argue that the greatest limitation of qualitative studies is the lack of generalizability, others contend that qualitative work has its own set of criteria that when

met, the findings can be generalized across similar populations (Maxwell 1992; Myers 2000; Schofield 2002). This study, like most ethnographies, focused on exploring meanings of concepts that are shaped by culture (expectations, values, and beliefs) within specific contexts. Therefore, the goal was not to generalize but to weave observations together to identify patterns and propose explanations that can be further explored using other methodologies.

One important caveat when considering findings from this study is that even among low income Blacks in ULH, there may be other sources of variability in the construction of salient stressors, and in how individuals respond to stress or express distress. Even though I focused on identifying repeated behaviors, actions, and thoughts, as well as their contexts and the meanings attributed to them, these patterns and phenomena are still subject to within group variation and to my own cultural understanding and interpretation. These complexities of culture - researcher versus participants, within group variations – as well as the dynamic nature of culture call for caution when interpreting the findings from this work. Within group variations in the manifestation of cultural processes require more rigorous research on cultural influences on mental health, and in the identification of specific cultural variables that can be manipulated to improve mental health research and mental health outcomes (Cardemil 2010a).

A second caveat is that this study did not specifically assess the role of factors such as gender, age, education, income, length of residency in ULH, and current or past use of mental health services. These factors potentially affect perceptions of stress, access to certain culturally salient resources, and perceptions of mental disorders.

Finally, during the ethnography, some participants might have presented ideal behaviors and patterned their communications and interactions to present what they thought I would like to hear and see. Sometimes, when I introduced my work after a casual conversation, some individuals readjusted their looks and changed their tones. For some of my key contacts, this occurred at the initial stage of the fieldwork, leading me to revisit several initial conversations later on in the process after rapport had been developed. It is likely that some of the responses I received throughout the ethnography were still biased by social desirability. As elaborated in section 3.6 about positionality, my socio-demographic characteristics (college-educated, female), racial identity (Black), and my national origin shaped my relationships with individuals in ULH and the kind of data that were collected. Moreover, impression management may have played a big part in determining how some residents interacted with me as well characteristics of themselves that they chose to present.

8.6 Implications and Recommendations

Despite the above limitations, my findings have theoretical, research, policy and practice implications. Theoretically, these findings provide evidence that supports the expansion of the stress process paradigm. Cultural context, meanings and expectations shape the stress process. The severity of a stressful event and the social vulnerability to an objective stressor are influenced by cultural and contextual factors. This work demonstrates that stressors are culturally constructed. The context of stress then plays an important role in shaping stress responses and resources, and whether negative mental health is experienced. Future qualitative and quantitative research applications of the stress

process that account for culture (and test cultural variables) are important next steps in further assessing how culture plays out in the stress process in different populations.

Findings also call for more research on the associations between race, impression management and specific mental disorders and types of emotional distress as conceptualized by the population under study. I hypothesize that Blacks practice impression management more so than Whites because of the pervasiveness of anti-Black racism and negative stereotypes about Blacks. Although racial socialization and cultural education about racism are associated with ways of dealing with stress such as to directly counter stereotypes (Burt, Simons, and Gibbons 2012; Granberg et al. 2012), resilience, if any, that might emerge from mastering race-related stressors comes at great costs (i.e., emotional labor from impression management, increased vulnerability to objective stressors, and poor physical health from John Henrysism).

The assumption of resilience among African Americans is likely to produce silence around mental health problems and any experiences thought to be at odds with narratives of strength and resilience. Given that African Americans are still physically sicker and poorer, and conceptualize mental disorders as a weakness while validating physical illnesses, the story of resilience with respect to mental health is debatable. If American Americans are much more resilient, why are they sicker (at least, physically) than their White counterparts? Research needs to critically investigate who and what contributes to maintaining these narratives of resilience, and how they might contribute to worse physical health among African Americans. It is also important to assess whether there are other attributes, characteristics or resources among African Americans correlated with

notions of strength and resilience that might offer some protection against common mental disorders.

The findings from my work also have research implications, especially around measurement of mental disorders in community surveys. First, current instruments to assess mental health may not be efficient or valid across populations because of varying cultural norms that determine whether individuals would acknowledge certain symptoms, or because of cultural ways of expressing mental health problems. If one were to administer standardized instruments for assessing depression in ULH, expressions of depression such as paranoia, rage, and anger would be missed. The prevalence of depression as conceptualized in ULH would be biased because individuals whose most common expressions of depression include rage, anger, or paranoia would not be captured.

Second, survey instruments fail to capture meanings of symptoms. One suggestion from this study is that it might be useful to identify cultural variables and find ways of operationalizing them in surveys. For example, questions about meanings of symptoms that they experience, and their perceived consequences. Making connections between cultural variables within and across different populations might improve our current understanding of the epidemiology of mental disorders, and might help clinicians and researchers to better understand the etiology of mental illnesses. It may also be useful for mental health researchers to compliment epidemiological surveys with contextual information about symptoms, and the cultural or shared meanings of symptoms.

In terms of policy, the study identified salient sources of stress in ULH such as racism, police harassment, gun violence and lack of structural resources that require policy interventions. These issues are interrelated, and significantly reduce the quality of life and the life chances of African Americans. Recommendations to eliminate these sources of stress include meaningful engagement in racial effects analysis of policies, practices, and programs of both government and private agencies and institutions in ULH, across the state, and in the country. Anti-racism efforts are crucial if there is real interest in addressing disadvantage in ULH and other inner city neighborhoods across the country.

Several small non-profit organizations in ULH are struggling because of limited resources. Identifying and supporting these organizations, and establishing partnerships would expand their reach and increase positive outcomes in the community. These partnerships could cut across several government agencies, religious institutions, businesses, and educational institutions. In general, policies that improve access to resources, better housing conditions, positive educational experiences and achievements, safety, and employment opportunities will reduce exposure and vulnerability to stressors in ULH.

The results also have implications for practice including how the provision of mental health care might benefit from a better understanding of how culture shapes expressions of distress. For example, diagnosis of depression in ULH would not only depend on diagnostic categories and concepts understood by the clinician, but would largely be a function of the presentation of depression by residents of ULH that are shaped by cultural and contextual factors. There are now increasing calls for patient-centered care as a means to improve quality of health care and reduce costs (Hibbard 2014; Mirzaei et al.

2013; Richards, Coulter, and Wicks 2015). Clinicians are expected to provide care that is consistent with the context, perspectives, and preferences of patients (Selby, Beal, and Frank 2012). Findings from this study are an additional resource to clinicians in ULH for the provision of patient-centered mental health care.

But the stigma around mental illnesses may prevent African Americans in ULH from going to mental health clinics for care. Most patients' initial interaction with the health care system is at the level of primary care. Integrating primary and mental health might go a long way to reduce stigma and improve utilization (Butler et al. 2008). With the ACA, some primary care practices operate as patient-centered medical homes that provide care for individuals with mild to moderate behavioral health problems (Casalino et al. 2010). This model could link persons who already receive services for other medical conditions to mental health care, thereby reducing some stigma barriers to care. In addition, African Americans are likely to go to other African American mental health providers (Jimenez et al. 2012). Developing a racially diverse work force will go a long way to address mental health problems among African Americans. It is also important to improve cultural humility, especially around mental health, as this will place health care workers in a better position to address the needs of African American patients.

In general, mental health providers should engage with relevant cultural information during the clinical encounter as this information will assist both clinicians and their patients to make best decisions about the mental health care of patients. The cultural formulation interview (CFI) of the DSM V is meant to help clinicians to assess culture in the diagnosis and provision of care to improve outcomes of care. It operationalizes "cultural definitions of the clinical problem, perceptions of cause, context and support,

and treatment factors (including self-coping and help-seeking patterns)" (Alarcon 2014:311). Initial studies on its usefulness in accessing cultural information found the CFI to help clinicians know the patient better, and to improve provider and patient satisfaction with medical communication (Aggarwal 2013; Aggarwal 2015).

However, research still needs to assess whether collecting cultural information using the CFI is associated with improved mental health outcomes especially among non-White populations. Other challenges with the CFI include time for implementation and limited clinician buy-in (Aggarwal 2013; Alarcón 2014). In addition, the CFI views the patients' background, identity, friends, and family as the sources of cultural information. It is imperative for clinicians to understand how the biomedical system as a culture influences patients' concepts of illness, risks, resilience and treatment, and how as members of this culture, clinicians themselves can be more reflective of their role in shaping a patient's symptom expression, experience of illness, and response to treatment. The CFI also falls short of providing guidance to clinicians on how to use the cultural information elicited during the interview to improve care. For example, clinicians in ULH must be able to evaluate how the knowledge that role strain is a salient stressor would help patients manage the stressor or prevent continual exposure with respect to mental health.

8.7 Conclusion

In conclusion, culture affects the stress process among African Americans in three ways. First, culture provides acceptable ways of dealing with stress such as John Henryisim, religious rituals that generate positive emotions, and shared behavioral and cognitive

responses to stress such as impression management. Second, mental health problems such as depression are perceived as a weakness. Therefore, there is hesitation to acknowledge some classic symptoms on surveys and in the clinical encounter. Third, expressions of depression that are not in survey instruments or in the DSM-V may lead to poor measurement and diagnosis.

Consistent with PCORI priorities (Selby, Beal, and Frank 2012), this community-based work identified and described the population-specific burden of chronic stress on mental health. The delivery of patient-centered mental health care certainly depends on evidence about risk and resilience, knowledge on protective resources and factors that increase vulnerability, and ultimately, different possible ways by which symptoms are expressed. This study has established what the community's culture-specific risk factors, resources and symptom presentations are with respect to mental health problems. The next steps are to assess culture at the clinical encounter, and examine how it affects continuous utilization of mental health services.

Although this work highlights cultural factors in the experience of stress, response to stress and mental health outcomes of stress, these cultural factors only have meaning within a specific context. The certainty of today may not be the reality tomorrow. Culture and communities are dynamic. As research continues to explore the role of culture in mental health, researchers should be cautious to integrate cultural factors into the different contexts in which they exist. They should also be mindful that culture, when poorly applied and misunderstood, can reinforce stereotypes (Kleinman and Benson 2006).

BIBLIOGRAPHY

Åberg Yngwe, Monica, Johan Fritzell, Olle Lundberg, Finn Diderichsen and Bo Burström. 2003. "Exploring relative deprivation: is social comparison a mechanism in the relation between income and health?" *Social Science & Medicine* 57(8):1463-1473.

Achenbach, Thomas M. 2001. "What are norms and why do we need valid ones?" *Clinical Psychology: Science and Practice* 8(4):446-450.

Adebimpe, V. R., J. L. Hedlund, D. W. Cho and J. B. Wood. 1982. "Symptomatology of depression in black and white patients." *Journal of the National Medical Association* 74(2):185-190.

Adelman, R. M. 2004. "Neighborhood opportunities, race, and class: The Black middle class and residential segregation." *City & Community* 3(1):43-63.

Adler, Nancy E. and Katherine Newman. 2002. "Socioeconomic disparities in health: pathways and policies." *Health Affairs* 21(2):60-76.

Agar, Michael H. 1996. "The professional stranger: An informal introduction to ethnography." (Vol. 2). San Diego, CA: Academic Press.

Agbayani-Siewert, P., D. T. Takeuchi and R. W. Pangan. 1999. "Mental illness in a multicultural context." *Handbook of the Sociology of Mental Health*:19-36.

Aggarwal, Neil K. 2013. "Cultural Psychiatry, Medical Anthropology, and the DSM-5 Field Trials." *Medical Anthropology*.

Aggarwal, Neil. 2015. "Does the Cultural Formulation Interview for the fifth revision of the diagnostic and statistical manual of mental disorders (DSM-5) affect medical

communication? A qualitative exploratory study from the New York site." *Ethnicity & Health* 20(1):1-28.

Ahern, J. and S. Galea. 2011. "Collective efficacy and major depression in urban neighborhoods." *American Journal of Epidemiology* 173(12):1453-1462.

Ajibade, Adebayo, Joshua N. Hook, Shawn O. Utsey, Don E. Davis and Daryl R. Van Tongeren. 2015. "Racial/Ethnic Identity, Religious Commitment, and Well-Being in African Americans." *Journal of Black Psychology*:0095798414568115.

Alang, Sirry M. 2015. "Sociodemographic Disparities Associated With Perceived Causes of Unmet Need for Mental Health Care." *Psychiatric Rehabilitation Journal*. dx.doi.org/10.1037/prj0000113

------. 2014. "Racial Variations in the Effects of Structural and Psychological Factors on Depressive Symptoms: A Structural Equation Modeling Approach." *Mental Health & Prevention* 2(1), 2-10.

Alarcon, Renato D. 1995. "Culture and psychiatric diagnosis: Impact on DSM-IV and ICD-10." *Psychiatric Clinics of North America*.18(3), 449-465.

Alarcón, Renato D. 2014. "Cultural inroads in DSM-5." *World Psychiatry* 13(3):310-313.

Alegría, M. and T. McGuire. 2003. "Rethinking a universal framework in the psychiatric symptom-disorder relationship." *Journal of Health and Social Behavior*:257-274.

Alegría, Margarita, Arlene Katz, Rachel Z. Ishikawa, Yaminette Diaz-Linhart, Anne Valentine and Sheri Lapatin. 2012. "The Role of Sociocultural Information in Mental Health Intake Sessions." *The Israel Journal of Psychiatry and Related Sciences* 49(3):194.

Alegria, M., R. Robles, D. H. Freeman, M. Vera, A. L. Jimenez, C. Rios and R. Rios. 1991. "Patterns of mental health utilization among island Puerto Rican poor." *American Journal of Public Health* 81(7):875-879.

Alleyne, Emma and Jane L. Wood. 2010. "Gang involvement: Psychological and behavioral characteristics of gang members, peripheral youth, and nongang youth." *Aggressive Behavior* 36(6):423-436.

Alverson, Hoyt, Marianne Alverson and Robert E. Drake. 2000. "An ethnographic study of the longitudinal course of substance abuse among people with severe mental illness." *Community Mental Health Journal* 36(6):557-569.

Anderson, Elijah. 1999. *Code of the Street.* New York: Norton.

Anderson, Elijah and Douglas S. Massey. 2004. *Problem of the century: Racial stratification in the United States.* Russell Sage Foundation.

Aneshensel, C. S. 2009. "Toward explaining mental health disparities." *Journal of Health and Social Behavior* 50(4):377-394.

Aneshensel, C. S., C. M. Rutter and P. A. Lachenbruch. 1991. "Social structure, stress, and mental health: Competing conceptual and analytic models." *American Sociological Review*:166-178.

Aneshensel, Carol S. and Leonard I. Pearlin. 1987. "Structural contexts of sex differences in stress." in Gender and stress, (pp. 75-95).Barnett, Rosalind C. (Ed); Biener, Lois (Ed); Baruch, Grace K. (Ed), New York, NY, US: Free Press

Aneshensel, Carol S. and Clea A. Sucoff. 1996. "The neighborhood context of adolescent mental health." *Journal of Health and Social Behavior*:293-310.

Angel, Ronald and Peter J. Guarnaccia. 1989. "Mind, body, and culture: somatization among Hispanics." *Social Science & Medicine* 28(12):1229-1238.

Anglin, Deidre, Bruce Link and Jo Phelan. 2006. "Racial differences in stigmatizing attitudes toward people with mental illness." *Psychiatric Services* 57(6):857-862.

Ashford, Susan J. and Gregory B. Northcraft. 1992. "Conveying more (or less) than we realize: The role of impression-management in feedback-seeking." *Organizational Behavior and Human Decision Processes* 53(3):310-334.

Atkinson, P., A. Coffey, S. Delamont, J. Lofland and L. Lofland. 2001. "Handbook of ethnography." *Thousand Oaks, London*.

Atkinson, P. and M. Hammersley. 1994. "Ethnography and participant observation." *Handbook of Qualitative Research* 1:248-261.

Avison, William R. and R. J. Turner. 1988. "Stressful life events and depressive symptoms: Disaggregating the effects of acute stressors and chronic strains." *Journal of Health and Social Behavior*:253-264.

Ayalon, Liat and Michael A. Young. 2003. "A comparison of depressive symptons in African Americans and Caucasian Americans." *Journal of Cross-Cultural Psychology* 34(1):111-124.

Baer, Roberta D., Susan C. Weller, de Alba Garcia, Javier Garcia, Mark Glazer, Robert Trotter, Lee Pachter and Robert E. Klein. 2003. "A cross-cultural approach to the study of the folk illness nervios." *Culture, Medicine and Psychiatry* 27(3):315-337.

Barg, Frances K., Rebecca Huss-Ashmore, Marsha N. Wittink, Genevra F. Murray, Hillary R. Bogner and Joseph J. Gallo. 2006. "A mixed-methods approach to understanding loneliness and depression in older adults." *The Journals of*

Gerontology Series B: Psychological Sciences and Social Sciences 61(6):S329-S339.

Barnes, Sandra L. 2005. "Black church culture and community action." *Social Forces* 84(2):967-994.

Batinic, Bernad, Eva Selenko, Barbara Stiglbauer and Karsten I. Paul. 2010. "Are workers in high-status jobs healthier than others? Assessing Jahoda's latent benefits of employment in two working populations." *Work & Stress* 24(1):73-87.

Beard, John R., Magda Cerdá, Shannon Blaney, Jennifer Ahern, David Vlahov and Sandro Galea. 2009. "Neighborhood characteristics and change in depressive symptoms among older residents of New York City." *Journal Information* 99(7).

Belgrave, F. Z. and K. W. Allison. 2009. *African American psychology: From Africa to America.* Sage Publications, Incorporated.

Bell, Janice F., Frederick J. Zimmerman, Gunnar R. Almgren, Jonathan D. Mayer and Colleen E. Huebner. 2006. "Birth outcomes among urban African-American women: a multilevel analysis of the role of racial residential segregation." *Social Science & Medicine* 63(12):3030-3045.

Bernard, Harvey R. 2011. *Research methods in anthropology.* Rowman Altamira.

Berntson, Gary G., John T. Cacioppo and Karen S. Quigley. 1993. "Respiratory sinus arrhythmia: autonomic origins, physiological mechanisms, and psychophysiological implications." *Psychophysiology* 30(2):183-196.

Berry, JW and DL Sam. 1995. "Culture and ethnic factors in health." *Cambridge Handbook of Psychology, Health and Medicine*:84-96.

Bhandari, Vijay K., Margot Kushel, Leonard Price and Dean Schillinger. 2005. "Racial disparities in outcomes of inpatient stroke rehabilitation." *Archives of Physical Medicine and Rehabilitation* 86(11):2081-2086.

Bhui, Kamaldeep and Sokratis Dinos. 2008. "Health beliefs and culture." *Disease Management & Health Outcomes* 16(6):411-419.

Bierman, A. 2006. "Does religion buffer the effects of discrimination on mental health? Differing effects by race." *Journal for the Scientific Study of Religion* 45(4):551-565.

Booth, Jaime, Stephanie L. Ayers and Flavio F. Marsiglia. 2012. "Perceived Neighborhood Safety and Psychological Distress: Exploring Protective Factors." *J.Soc.& Soc.Welfare* 39:137.

Borrell, Luisa N., Florence J. Dallo and Norma Nguyen. 2010. "Racial/ethnic disparities in all-cause mortality in US adults: the effect of allostatic load." *Public Health Reports* 125(6):810.

Bourgois, Philippe, Alexis Martinez, Alex Kral, Brian R. Edlin, Jeff Schonberg and Dan Ciccarone. 2006. "Reinterpreting ethnic patterns among white and African American men who inject heroin: a social science of medicine approach." *PLoS Medicine* 3(10):e452.

Bovier, Patrick A., Eric Chamot and Thomas V. Perneger. 2004. "Perceived Stress, Internal Resources, and Social Support as Determinants of Mental Health among Young Adults." *Quality of Life Research* 13(1):161-170

Bowling, Ann and Mai Stafford. 2007. "How do objective and subjective assessments of neighbourhood influence social and physical functioning in older age? Findings from a British survey of ageing." *Social Science & Medicine* 64(12):2533-2549.

Bradley, E. H., L. A. Curry and K. J. Devers. 2007. "Qualitative data analysis for health services research: developing taxonomy, themes, and theory." *Health Services Research* 42(4):1758-1772.

Bratter, J. L. and K. Eschbach. 2005. "Race/Ethnic Differences in Nonspecific Psychological Distress: Evidence from the National Health Interview Survey*." *Social Science Quarterly* 86(3):620-644. Retrieved 5/3/2012 4:21:22 PM.

Braveman, Paula A., Catherine Cubbin, Susan Egerter, David R. Williams and Elsie Pamuk. 2010. "Socioeconomic disparities in health in the United States: what the patterns tell us." *American Journal of Public Health* 100(S1):S186-S196.

Braveman, Paula, Catherine Cubbin, Kristen Marchi, Susan Egerter and Gilberto Chavez. 2001. "Measuring socioeconomic status/position in studies of racial/ethnic disparities: maternal and infant health." *Public Health Reports* 116(5):449.

Breslau, J., K. N. Javaras, D. Blacker, J. M. Murphy and S. L. T. Normand. 2008. "Differential item functioning between ethnic groups in the epidemiological assessment of depression." *The Journal of Nervous and Mental Disease* 196(4):297.

Breslau, J., K. S. Kendler, M. Su, S. Gaxiola-Aguilar and R. C. Kessler. 2005. "Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States." *Psychological Medicine* 35(03):317-327.

Breslau, Joshua, Sergio Aguilar-Gaxiola, Kenneth S. Kendler, Maxwell Su, David Williams and Ronald C. Kessler. 2006. "Specifying race-ethnic differences in risk for psychiatric disorder in a USA national sample." *Psychological Medicine* 36(01):57

Broman, C. L. 1996. "The health consequences of racial discrimination: a study of African Americans." *Ethnicity & Disease* 6(1-2):148-153.

Bronder, Ellen C., Suzette L. Speight, Karen M. Witherspoon and Anita J. Thomas. 2014. "John Henryism, depression, and perceived social support in black women." *Journal of Black Psychology* 40(2):115-137.

------. 2013. "John Henryism, Depression, and Perceived Social Support in Black Women." *Journal of Black Psychology*.

Brown, Charlotte, Kyaien O. Conner, Valire C. Copeland, Nancy Grote, Scott Beach, Deena Battista and Charles F. Reynolds. 2010. "Depression stigma, race, and treatment seeking behavior and attitudes." *Journal of Community Psychology* 38(3):350-368.

Brown, George G. W. and Tirril Harris. 1989. *Life events and illness.* Guilford Press.

Brown, T. N., S. L. Sellers, K. T. Brown and J. S. Jackson. 1999. "Race, ethnicity, and culture in the sociology of mental health." *Handbook of the Sociology of Mental Health*:167-182.

Browning, C. R., K. A. Cagney and M. Wen. 2003. "Explaining variation in health status across space and time: implications for racial and ethnic disparities in self-rated health." *Social Science and Medicine* 57(7):1221-1236.

Browning, Christopher R. and Kathleen A. Cagney. 2002. "Neighborhood structural disadvantage, collective efficacy, and self-rated physical health in an urban setting." *Journal of Health and Social Behavior*:383-399.

Bruce, Marino A., Bettina M. Beech, Mario Sims, Tony N. Brown, Sharon B. Wyatt, Herman A. Taylor, David R. Williams and Errol Crook. 2009. "Social environmental

stressors, psychological factors, and kidney disease." *Journal of Investigative Medicine: The Official Publication of the American Federation for Clinical Research* 57(4):583.

Brunner, Eric. 1997. "Stress and the biology of inequality." *BMJ: British Medical Journal* 314(7092):1472.

Burgess, Robert G. 2002. *In the field: An introduction to field research.* Psychology Press.

Burke, P. J. 1991. "Identity processes and social stress." *American Sociological Review*:836-849.

Burt, C. H., R. L. Simons and F. X. Gibbons. 2012. "Racial Discrimination, Ethnic-Racial Socialization, and Crime: A Micro-sociological Model of Risk and Resilience." *American Sociological Review* 77(4):648-677.

Burton, Deron C., Brendan Flannery, Nancy M. Bennett, Monica M. Farley, Ken Gershman, Lee H. Harrison, Ruth Lynfield, Susan Petit, Arthur L. Reingold and William Schaffner. 2010. "Socioeconomic and racial/ethnic disparities in the incidence of bacteremic pneumonia among US adults." *American Journal of Public Health* 100(10):1904-1911.

Butler, M., Kane, R. L., McAlpine, D., Kathol, R. G., Fu, S. S., Hagedorn, H., & Wilt, T. J. 2008. Integration of mental health/substance abuse and primary care. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Oct. (Evidence Reports/Technology Assessments, No. 173)

Canino, G. and M. Alegría. 2008. "Psychiatric diagnosis–is it universal or relative to culture?" *Journal of Child Psychology and Psychiatry* 49(3):237-250.

Cardemil, Esteban V. 2010a. "The complexity of culture: Do we embrace the challenge or avoid it?" *Scientific Review of Mental Health Practice* 7(2).

------. 2010b. "Cultural adaptations to empirically supported treatments: A research agenda." *The Scientific Review of Mental Health Practice* 7(2):8-21.

Carey, Lisa A., Charles M. Perou, Chad A. Livasy, Lynn G. Dressler, David Cowan, Kathleen Conway, Gamze Karaca, Melissa A. Troester, Chiu K. Tse and Sharon Edmiston. 2006. "Race, breast cancer subtypes, and survival in the Carolina Breast Cancer Study." *JAMA: The Journal of the American Medical Association* 295(21):2492-2502.

Carlson, ED and RM Chamberlain. 2005. "Allostatic load and health disparities: a theoretical orientation." *Research in Nursing & Health* 28(4):306-315.

Casalino, L. P., Rittenhouse, D. R., Gillies, R. R., & Shortell, S. M. 2010. Specialist physician practices as patient-centered medical homes. *The New England Journal of Medicine*, 362, 1555–1558.

Caspi, Avshalom, Niall Bolger and John Eckenrode. 1987. "Linking person and context in the daily stress process." *Journal of Personality and Social Psychology* 52(1):184.

Castillo, Richard J. 1997. *Culture & mental illness: A client-centered approach.* Thomson Brooks/Cole Publishing Co.

Celious, Aaron and Daphna Oyserman. 2001. "Race from the inside: An emerging heterogeneous race model." *Journal of Social Issues* 57(1):149-165.

Chambers, John W., Kobi Kambon, Bobbi D. Birdsong, Jamye Brown, Pamela Dixon and Larmia Robbins-Brinson. 1998. "Africentric cultural identity and the stress

experience of African American college students." *Journal of Black Psychology* 24(3):368-396.

Chapman, L. K. and Michael F. Steger. 2010. "Race and religion: Differential prediction of anxiety symptoms by religious coping in African American and European American young adults." *Depression and Anxiety* 27(3):316-322.

Charles, Camille Z. 2003. "The dynamics of racial residential segregation." *Annual Review of Sociology*:167-207.

Chou, Kee-Lee. 2012. "Perceived discrimination and depression among new migrants to Hong Kong: the moderating role of social support and neighborhood collective efficacy." *Journal of Affective Disorders* 138(1):63-70.

Chrousos, George P. and Philip W. Gold. 1992. "The concepts of stress and stress system disorders." *JAMA: The Journal of the American Medical Association* 267(9):1244-1252.

Chyu, Laura and Dawn M. Upchurch. 2011. "Racial and ethnic patterns of allostatic load among adult women in the United States: findings from the National Health and Nutrition Examination Survey 1999–2004." *Journal of Women's Health* 20(4):575-583.

Clark, Cheryl R., Ichiro Kawachi, Louise Ryan, Karen Ertel, Martha E. Fay and Lisa F. Berkman. 2009. "Perceived neighborhood safety and incident mobility disability among elders: the hazards of poverty." *BMC Public Health* 9(1):162.

Clark, Rodney, Norman B. Anderson, Vernessa R. Clark and David R. Williams. 1999. "Racism as a stressor for African Americans: A biopsychosocial model." *American Psychologist* 54(10):805.

Clark, V. A., C. S. Aneshensel, R. R. Frerichs and T. M. Morgan. 1981. "Analysis of effects of sex and age in response to items on the CES-D scale." *Psychiatry Research* 5(2):171-181.

Cobb, S. 1976. "Presidential Address-1976. Social support as a moderator of life stress." *Psychosomatic Medicine* 38(5):300-314.

Cockerham, W. C., Hinote, B. P., Cockerham, G. B., & Abbott, P. 2006. Health lifestyles and political ideology in Belarus, Russia, and Ukraine. *Social Science & Medicine*, 62(7), 1799-1809.

Cohen, Deborah A., Brian K. Finch, Aimee Bower and Narayan Sastry. 2006. "Collective efficacy and obesity: the potential influence of social factors on health." *Social Science & Medicine* 62(3):769-778.

Collins, Rebecca L. 1996. "For better or worse: The impact of upward social comparison on self-evaluations." *Psychological Bulletin* 119(1):51.

Collins, R. 1994. *Four Sociological traditions: selected readings.*

Conley, Dalton. 2001. "Decomposing the Black-White Wealth Gap: The Role of Parental Resources, Inheritance, and Investment Dynamics." *Sociological Inquiry* 71(1):39-66.

Conner, Kyaien O., Valire C. Copeland, Nancy K. Grote, Gary Koeske, Daniel Rosen, Charles F. Reynolds III and Charlotte Brown. 2010. "Mental health treatment seeking among older adults with depression: the impact of stigma and race." *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry* 18(6):531.

Cooley, Charles H. 1902. "The looking-glass self." *O'Brien*:126-128.

Costa, Giovanni. 1996. "The impact of shift and night work on health." *Applied Ergonomics* 27(1):9-16.

Creswell, J. W. 2012. *Qualitative inquiry and research design: Choosing among five approaches.* SAGE Publications, Incorporated.

------. 2009. *Research design: Qualitative, quantitative, and mixed methods approaches.* Sage.

Creswell, John W., Vicki L. Plano Clark, Michelle L. Gutmann and William E. Hanson. 2003. "Advanced mixed methods research designs." *Handbook of Mixed Methods in Social and Behavioral Research*:209-240.

Crimmins, Eileen M., Mark D. Hayward and Teresa E. Seeman. 2004. "Race/ethnicity, socioeconomic status, and health." *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life*:310-352.

Cutler, David M. and Adriana Lleras-Muney. 2010. "Understanding differences in health behaviors by education." *Journal of Health Economics* 29(1):1-28.

Cutrona, C. E., D. W. Russell, R. M. Hessling, P. A. Brown and V. Murry. 2000. "Direct and moderating effects of community context on the psychological well-being of African American women." *Journal of Personality and Social Psychology; Journal of Personality and Social Psychology* 79(6):1088.

Cutrona, Carolyn E., Daniel W. Russell, P. A. Brown, Lee A. Clark, Robert M. Hessling and Kelli A. Gardner. 2005. "Neighborhood context, personality, and stressful life events as predictors of depression among African American women." *Journal of Abnormal Psychology* 114(1):3.

Danquah, Meri N. 1998. *Willow weep for me: A Black woman's journey through depression.* Norton.

Diala, C. C., C. Muntaner, C. Walrath, K. Nickerson, T. LaVeist and P. Leaf. 2001. "Racial/ethnic differences in attitudes toward seeking professional mental health services." *American Journal of Public Health* 91(5):805-807.

Diez Roux, A. V. 2001. "Investigating neighborhood and area effects on health." *American Journal of Public Health* 91(11):1783-1789.

Djuric, Zora, Chloe E. Bird, Alice Furumoto-Dawson, Garth H. Rauscher, Mack T. Ruffin IV, Raymond P. Stowe, Katherine L. Tucker and Christopher M. Masi. 2008. "Biomarkers of psychological stress in health disparities research." *The Open Biomarkers Journal* 1:7.

Dohrenwend, B. P. 1975. "Sociocultural and social-psychological factors in the genesis of mental disorders." *Journal of Health and Social Behavior*:365-392.

Dohrenwend, Barbara S. and Bruce P. Dohrenwend. 1982. "Some issues in research on stressful life events." Pp. 91-102 in *Handbook of clinical health psychology*"Some issues in research on stressful life events."Springer.

Dohrenwend, Bruce P. 2006. "Inventorying stressful life events as risk factors for psychopathology: Toward resolution of the problem of intracategory variability." *Psychological Bulletin* 132(3):477.

Dohrenwend, Bruce P., Karen G. Raphael, Sharon Schwartz, Ann Stueve and Andrew Skodol. 1993. "The structured event probe and narrative rating method for measuring stressful life events." in Handbook of Stress: Theoretical and clinical

aspects (2nd ed.) , (pp. 174-199) Goldberger, Leo (Ed); Breznitz, Shlomo (Ed), New York, NY, US: Free Press

Dressler, William W., Mauro C. Balieiro, Rosane P. Ribeiro and Jose E. dos Santos. 2007. "A prospective study of cultural consonance and depressive symptoms in urban Brazil." *Social Science & Medicine* 65(10):2058-2069.

Dressler, William W., Mauro C. Balieiro and Jose E. D. Santos. 1998. "Culture, socioeconomic status, and physical and mental health in Brazil." *Medical Anthropology Quarterly* 12(4):424-446.

Du Bois, William Edward Burghardt and Isabel Eaton. 1899. *The Philadelphia Negro: a social study.* Published for the University.

Duneier, Mitchell. 1999. *Sidewalk.* Macmillan.

Dunlop, D. D., J. Song, J. S. Lyons, L. M. Manheim and R. W. Chang. 2003. "Racial/ethnic differences in rates of depression among preretirement adults." *American Journal of Public Health* 93(11):1945-1952.

Dupere, V., T. Leventhal and F. Vitaro. 2012. "Neighborhood processes, self-efficacy, and adolescent mental health." *Journal of Health and Social Behavior* 53(2):183-198.

Duru, O. K., Nina T. Harawa, Dulcie Kermah and Keith C. Norris. 2012. "Allostatic Load Burden and Racial Disparities in Mortality." *Journal of the National Medical Association* 104(1-2):89.

Earl, Tara R., Margarita Alegría, Frances Mendieta and Yaminette D. Linhart. 2011. ""“Just Be Straight With Me:” An Exploration of Black Patient Experiences in Initial Mental Health Encounters." *American Journal of Orthopsychiatry* 81(4):519-525.

Eid, Michael and Ed Diener. 2001. "Norms for experiencing emotions in different cultures: inter-and intranational differences." *Journal of Personality and Social Psychology* 81(5):869.

Emerson, Robert M. 2001a. "The face of contemporary ethnography." *Contemporary Field Research: Perspectives and Formulations* 2:27-54.

------. 2001b. "Producing ethnographies: theory, evidence and representation." *Contemporary Field Research*:295.

------. 1987. "Four ways to improve the craft of fieldwork." *Journal of Contemporary Ethnography* 16(1):69-89.

------. 1981. "Observational field work." *Annual Review of Sociology* 7:351-378.

Emerson, Robert M., Rachel I. Fretz and Linda L. Shaw. 2011. *Writing ethnographic fieldnotes.* University of Chicago Press.

Engel, G. L. 2004. "The need for a new medical model: a challenge for biomedicine." *The Social Psychology of Health*:51-63.

Eshun, Sussie and Regan A. Gurung. 2009. *Culture and mental health: Sociocultural influences, theory, and practice.* Wiley. com.

Fabrega, Horacio, Juan Mezzich and Richard F. Ulrich. 1988. "Black-white differences in psychopathology in an urban psychiatric population." *Comprehensive Psychiatry* 29(3):285-297.

Farmer, Melissa M. and Kenneth F. Ferraro. 2005. "Are racial disparities in health conditional on socioeconomic status?" *Social Science & Medicine* 60(1):191-204.

Feagin, Joe R. 1991. "The continuing significance of race: Antiblack discrimination in public places." *American Sociological Review*:101-116.

Feng, Zhiqiang and Paul Boyle. 2014. "Do Long Journeys to Work Have Adverse Effects on Mental Health?" *Environment and Behavior* 46(5):609-625.

Festinger, Leon. 1954. "A theory of social comparison processes." *Human Relations*.

Fischer, A. R. and C. M. Shaw. 1999. "African Americans' mental health and perceptions of racist discrimination: The moderating effects of racial socialization experiences and self-esteem." *Journal of Counseling Psychology* 46(3):395.

Fiske, John. 1992. "Cultural studies and the culture of everyday life." *Cultural Studies* 154:173.

Flier, J. S., L. H. Underhill and B. S. McEwen. 1998. "Protective and damaging effects of stress mediators." *New England Journal of Medicine* 338(3):171-179.

Fullilove, M. T., V. Heon, W. Jimenez, C. Parsons, L. L. Green and R. E. Fullilove. 1998. "Injury and anomie: effects of violence on an inner-city community." *American Journal of Public Health* 88(6):924-927.

Furnham, Adrian and R. Malik. 1994. "Cross-Cultural Beliefs About" Depression" A. Furnham & R. Malik." *International Journal of Social Psychiatry* 40(2):106-123.

Galea, Sandro, Jennifer Ahern, Arijit Nandi, Melissa Tracy, John Beard and David Vlahov. 2007. "Urban neighborhood poverty and the incidence of depression in a population-based cohort study." *Annals of Epidemiology* 17(3):171-179.

Galea, S., J. Ahern, S. Rudenstine, Z. Wallace and D. Vlahov. 2005. "Urban built environment and depression: a multilevel analysis." *Journal of Epidemiology and Community Health* 59(10):822-827.

Gallop, R. and L. O'Brien. 2003. "Re-establishing psychodynamic theory as foundational knowledge for psychiatric/mental health nursing." *Issues in Mental Health Nursing* 24(2):213-227.

Galster, George. 2001. "On the nature of neighbourhood." *Urban Studies* 38(12):2111-2124.

Gary, T. L., S. A. Stark and T. A. LaVeist. 2007. "Neighborhood characteristics and mental health among African Americans and whites living in a racially integrated urban community." *Health & Place* 13(2):569-575. Retrieved 5/3/2012 12:59:19 PM.

Geertz, Clifford. 1973. *The interpretation of cultures: Selected essays.* Basic Books (AZ).

Gerdtham, Ulf-G and Magnus Johannesson. 2004. "Absolute income, relative income, income inequality, and mortality." *Journal of Human Resources* 39(1):228-247.

Geronimus, Arline T., Margaret Hicken, Danya Keene and John Bound. 2006. ""“Weathering” and age patterns of allostatic load scores among blacks and whites in the United States." *Journal Information* 96(5).

Ghaemi, S. N. 2009. "The rise and fall of the biopsychosocial model." *The British Journal of Psychiatry* 195(1):3-4.

Givens, Jane L., Ira R. Katz, Scarlett Bellamy and William C. Holmes. 2007. "Stigma and the acceptability of depression treatments among African Americans and whites." *Journal of General Internal Medicine* 22(9):1292-1297.

Glaser, B. G. and A. L. Strauss. 1967. *The discovery of grounded theory: Strategies for qualitative research.* Aldine de Gruyter.

Goffman, Alice. 2014. *On the run: Fugitive life in an American city*. University of Chicago Press.

Goffman, E. 1961. "Asylums: Essays on the social situation of mental patients." *Garden City, NY: Anchor*.

Goffman, Erving. 1967. "Interaction ritual: essays on face-to-face interaction. Aldine. Oxford, England.

------. 1959. "The presentation of self in everyday life." Anchor. Garden City, NY.

Goldstein, David S. and Irwin J. Kopin. 2007. "Evolution of concepts of stress." *Stress: The International Journal on the Biology of Stress* 10(2):109-120.

Gould, Mark. 1999. "Race and theory: Culture, poverty, and adaptation to discrimination in Wilson and Ogbu." *Sociological Theory* 17(2):171-200.

Granberg, E. M., M. B. Edmond, R. L. Simons, F. X. Gibbons and M. K. Lei. 2012. "The Association between Racial Socialization and Depression: Testing Direct and Buffering Associations in a Longitudinal Cohort of African American Young Adults." *Society and Mental Health* 2(3), 207-225.

Gupta, Akhil and James Ferguson. 1992. "Beyond “culture”: Space, identity, and the politics of difference." *Cultural Anthropology* 7(1):6-23.

Handwerker, W. P. and Danielle F. Wozniak. 1997. "Sampling Strategies for the Collection of Cultural Data: An Extension of Boas's Answer to Galton's Problem1." *Current Anthropology* 38(5):869-875.

Hankerson, Sidney H., Kalycia T. Watson, Ellen Lukachko, Mindy T. Fullilove and Myrna Weissman. 2013. "Ministers’ perceptions of church-based programs to

provide depression care for african americans." *Journal of Urban Health* 90(4):685-698.

Harding, David, Michele Lamont and Mario L. Small. 2010. *Reconsidering culture and poverty.* SAGE.

Harlow, Roxanna. 2003. "" Race Doesn't Matter, but...": The Effect of Race on Professors' Experiences and Emotion Management in the Undergraduate College Classroom." *Social Psychology Quarterly*:348-363.

Harper, G. 2001. "Cultural influences on diagnosis." *Child and Adolescent Psychiatric Clinics of North America* 10(4):711-28

Harris, Katherine M., Mark J. Edlund and Sharon Larson. 2005. "Racial and ethnic differences in the mental health problems and use of mental health care." *Medical Care* 43(8):775-784.

Harris, Maureen I. 2001. "Racial and ethnic differences in health care access and health outcomes for adults with type 2 diabetes." *Diabetes Care* 24(3):454-459.

Haslam, N. 2000. "Psychiatric categories as natural kinds: Essentialist thinking about mental disorder." *Social Research*:1031-1058.

Hayward, Mark D., Toni P. Miles, Eileen M. Crimmins and Yu Yang. 2000. "The significance of socioeconomic status in explaining the racial gap in chronic health conditions." *American Sociological Review*:910-930.

Hellhammer, J., W. Schlotz, AA Stone, KM Pirke and D. Hellhammer. 2004. "Allostatic load, perceived stress, and health: a prospective study in two age groups." *Annals of the New York Academy of Sciences* 1032(1):8-13.

Heurtin-Roberts, S., L. Snowden and L. Miller. 1997. "Expressions of anxiety in African Americans: ethnography and the epidemiological catchment area studies." *Culture, Medicine and Psychiatry* 21(3):337-363.

Hibbard, J. 2014. "Activating patient-centred care can improve outcomes." *PharmacoEconomics & Outcomes News* 704:2-7.

Holt, Cheryl L., Min Q. Wang, Eddie M. Clark, Beverly R. Williams and Emily Schulz. 2013. "Religious involvement and physical and emotional functioning among African Americans: The mediating role of religious support." *Psychology & Health* 28(3):267-283.

Horwitz, Allan V. 2007. "Distinguishing distress from disorder as psychological outcomes of stressful social arrangements." *Health:* 11(3):273-289.

------. 2002. "Outcomes in the sociology of mental health and illness: Where have we been and where are we going?" *Journal of Health and Social Behavior*:143-151.

Howarth, Caroline. 2006. "Race as stigma: Positioning the stigmatized as agents, not objects." *Journal of Community & Applied Social Psychology* 16(6):442-451.

Hruschka, DJ and Craig Hadley. 2008. "A glossary of culture in epidemiology." *Journal of Epidemiology and Community Health* 62(11):947-951.

Hudson, C. G. 2005. "Socioeconomic status and mental illness: tests of the social causation and selection hypotheses." *American Journal of Orthopsychiatry* 75(1):3-18.

Hudson, Darrell L., Harold W. Neighbors, Arline T. Geronimus and James S. Jackson. 2015. "Racial Discrimination, John Henryism, and Depression Among African Americans." *Journal of Black Psychology*:0095798414567757.

Hudson, Darrell L., HW Neighbors, AT Geronimus and JS Jackson. 2012. "The relationship between socioeconomic position and depression among a US nationally representative sample of African Americans." *Social Psychiatry and Psychiatric Epidemiology* 47(3):373-381.

Hunter, L. R. and N. B. Schmidt. 2010. "Anxiety psychopathology in African American adults: literature review and development of an empirically informed sociocultural model." *Psychological Bulletin* 136(2):211.

Irby, Kimberly, William F. Anderson, Donald E. Henson and Susan S. Devesa. 2006. "Emerging and widening colorectal carcinoma disparities between Blacks and Whites in the United States (1975-2002)." *Cancer Epidemiology Biomarkers & Prevention* 15(4):792-797.

Jackson, A. P. and S. J. Sears. 1992. "Implications of an Africentric worldview in reducing stress for African American women." *Journal of Counseling & Development* 71(2):184-190.

Jackson, J. S. and K. M. Knight. 2006. "Race and self-regulatory health behaviors: the role of the stress response and the HPA axis in physical and mental health disparities." *Social Structures, Aging, and Self-Regulation in the Elderly.New York, NY: Springer*:189-207.

Jackson, J. S., K. M. Knight and J. A. Rafferty. 2010. "Race and unhealthy behaviors: chronic stress, the HPA axis, and physical and mental health disparities over the life course." *Journal Information* 100(5).

Jackson, P. B. and S. P. Lassiter. 2001. "Self-esteem and race." in Extending self-esteem theory and research: Sociological and psychological currents. (pp. 223-254) Owens, Timothy J. (Ed); Stryker, Sheldon (Ed); Goodman, Norman (Ed), .New York, NY,

James, Sherman A. 1994. "John Henryism and the health of African-Americans." *Culture, Medicine & Psychiatry* 18(2):163

Jimenez, D. E., Bartels, S. J., Cardenas, V., Dhaliwal, S. S., & Alegría, M. 2012. Cultural beliefs and mental health treatment preferences of ethnically diverse older adult consumers in primary care. *The American Journal of Geriatric Psychiatry,* 20(6), 533-542

Jimenez, Daniel E., Ben Cook, Stephen J. Bartels and Margarita Alegría. 2013. "Disparities in mental health service use of racial and ethnic minority elderly adults." *Journal of the American Geriatrics Society* 61(1):18-25.

Jones-Webb, R. J. and L. R. Snowden. 1993. "Symptoms of depression among blacks and whites." *American Journal of Public Health* 83(2):240-244.

Julius, Wilson W. 1987. "The truly disadvantaged: The inner city, the underclass, and public policy." *Chicago: The University of Chicago.*

Juster, Robert-Paul, Bruce S. McEwen and Sonia J. Lupien. 2010. "Allostatic load biomarkers of chronic stress and impact on health and cognition." *Neuroscience & Biobehavioral Reviews* 35(1):2-16.

Kahn, Joan R. and Elena M. Fazio. 2005. "Economic status over the life course and racial disparities in health." *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 60(Special Issue 2):S76-S84.

Kao, Hsueh-Fen S., Min-Tao Hsu and Lauren Clark. 2004. "Conceptualizing and critiquing culture in health research." *Journal of Transcultural Nursing* 15(4):269-277.

Karasz, A. 2005. "Cultural differences in conceptual models of depression." *Social Science & Medicine* 60(7):1625-1635.

Karlsen, Saffron and James Y. Nazroo. 2002. "Relation Between Racial Discrimination, Social Class, and Health Among Ethnic Minority Groups." *American Journal of Public Health* 92(4):624-631.

Kawachi, Ichiro and Lisa F. Berkman. 2003. "Neighborhoods and health.".

Kawachi, Ichiro, Bruce P. Kennedy and Richard G. Wilkinson. 1999. "Crime: social disorganization and relative deprivation." *Social Science & Medicine* 48(6):719-731.

Kawachi, I., B. P. Kennedy, K. Lochner and D. Prothrow-Stith. 1997. "Social capital, income inequality, and mortality." *American Journal of Public Health* 87(9):1491-1498.

Kelley, Robin D. 1997. *Yo'mama's disfunktional!: Fighting the culture wars in urban America.* Beacon Press.

Kessler, R. C., K. A. McGonagle, S. Zhao, C. B. Nelson, M. Hughes, S. Eshleman, H. U. Wittchen and K. S. Kendler. 1994. "Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey." *Archives of General Psychiatry* 51(1):8.

Kessler, R. C., R. H. Price and C. B. Wortman. 1985. "Social factors in psychopathology: Stress, social support, and coping processes." *Annual Review of Psychology* 36(1):531-572.

Kessler, R. C., S. Zhao, D. G. Blazer and M. Swartz. 1997. "Prevalence, correlates, and course of minor depression and major depression in the National Comorbidity Survey." *Journal of Affective Disorders* 45(1-2):19-30.

Kessler, Ronald C. 2002. "The categorical versus dimensional assessment controversy in the sociology of mental illness." *Journal of Health and Social Behavior*:171-188.

Kessler, Ronald C., Kristin D. Mickelson and David R. Williams. 1999. "The prevalence, distribution, and mental health correlates of perceived discrimination in the United States." *Journal of Health and Social Behavior*:208-230.

Kessler, R. C. 2005. "Prevalence and treatment of mental disorders, 1990 to 2003." *The New England Journal of Medicine* 352(24):2515.

Keyes, C. L. M. 2009. "The Black–White Paradox in Health: Flourishing in the Face of Social Inequality and Discrimination." *Journal of Personality* 77(6):1677-1706.

Keyes, KM, D. M. Barnes and LM Bates. 2011. "Stress, coping, and depression: testing a new hypothesis in a prospectively studied general population sample of US-born whites and blacks." *Social Science & Medicine* 72(5):650-659.

Keys, Hunter M., Bonnie N. Kaiser, Brandon A. Kohrt, Nayla M. Khoury and Aimée-Rika T. Brewster. 2012. "Idioms of distress, ethnopsychology, and the clinical encounter in Haiti's Central Plateau." *Social Science & Medicine* 75(3):555-564

Khan, Shamus and Colin Jerolmack. 2013. "Saying Meritocracy and Doing Privilege." *The Sociological Quarterly* 54(1):9-19.

Kiecolt, K. J., Michael Hughes and Verna M. Keith. 2009. "Can a high sense of control and John Henryism be bad for mental health?" *The Sociological Quarterly* 50(4):693-714.

Kiecolt, K., M. Hughes and V. M. Keith. 2008. "Race, social relationships, and mental health." *Personal Relationships* 15(2):229-245.

Kiecolt-Glaser, Janice K., Lynanne McGuire, Theodore F. Robles and Ronald Glaser. 2002. "Emotions, morbidity, and mortality: new perspectives from psychoneuroimmunology." *Annual Review of Psychology* 53(1):83-107.

Kim, D. 2008. "Blues from the neighborhood? Neighborhood characteristics and depression." *Epidemiologic Reviews* 30:101-117.

Kirmayer, L. J. 2005. "Culture, context and experience in psychiatric diagnosis." *Psychopathology* 38(4):192-196.

------. 1991. "The place of culture in psychiatric nosology: Taijin kyofusho and DSM-III—R." *Journal of Nervous and Mental Disease; Journal of Nervous and Mental Disease*.

Kirmayer, Laurence J. and Allan Young. 1998. "Culture and somatization: clinical, epidemiological, and ethnographic perspectives." *Psychosomatic Medicine* 60(4):420-430.

Kirmayer, Laurence J., Allan Young and Barbara C. Hayton. 1995. "The cultural context of anxiety disorders." *Psychiatric Clinics of North America*.

Kivimaki, Mika, Jane E. Ferrie, Eric Brunner, Jenny Head, Martin J. Shipley, Jussi Vahtera and Michael G. Marmot. 2005. "Justice at work and reduced risk of coronary heart disease among employees: the Whitehall II Study." *Archives of Internal Medicine* 165(19):2245.

Kleinman, A. 2004. "Culture and depression." *New England Journal of Medicine* 351(10):951-953.

Kleinman, Arthur. 1987. "Anthropology and psychiatry. The role of culture in cross-cultural research on illness." *The British Journal of Psychiatry* 151(4):447-454.

Kleinman, Arthur and Peter Benson. 2006. "Anthropology in the clinic: the problem of cultural competency and how to fix it." *PLoS Medicine* 3(10):e294.

Kondo, Naoki, Ichiro Kawachi, SV Subramanian, Yasuhisa Takeda and Zentaro Yamagata. 2008. "Do social comparisons explain the association between income inequality and health?: Relative deprivation and perceived health among male and female Japanese individuals." *Social Science & Medicine* 67(6):982-987.

Krause, Neal. 2006. "Exploring the stress-buffering effects of church-based and secular social support on self-rated health in late life." *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 61(1):S35-S43.

Kreuter, Matthew W. and Lorna T. Haughton. 2006. "Integrating culture into health information for African American women." *American Behavioral Scientist* 49(6):794-811.

Kreuter, Matthew W. and Stephanie M. McClure. 2004. "The role of culture in health communication." *Annu.Rev.Public Health* 25:439-455.

Krieger, N., A. Kosheleva, P. D. Waterman, J. T. Chen and K. Koenen. 2011. "Racial discrimination, psychological distress, and self-rated health among US-born and foreign-born black Americans." *American Journal of Public Health* 101(9):1704.

Krieger, N. (2000). Discrimination and health (pp. 36-75). L. F. Berkman (Ed.). Social epidemiology. New York: Oxford University Press.

Krieger, N. and S. Sidney. 1996. "Racial discrimination and blood pressure: the CARDIA Study of young black and white adults." *American Journal of Public Health* 86(10):1370-1378.

Kunda, Gideon. 2013. "Reflections on becoming an ethnographer." *Journal of Organizational Ethnography* 2(1):4-22.

Lamont, Michèle and Mario L. Small. 2008. "How culture matters: Enriching our understanding of poverty." *The Colors of Poverty: Why Racial and Ethnic Disparities Persist*:76-102.

Landrine, Hope and Elizabeth A. Klonoff. 1996. "The schedule of racist events: A measure of racial discrimination and a study of its negative physical and mental health consequences." *Journal of Black Psychology* 22(2):144-168.

------. 1992. "Culture and health-related schemas: a review and proposal for interdisciplinary integration." *Health Psychology* 11(4):267.

Lange, Rense, Michael A. Thalbourne, James Houran and David Lester. 2002. "Depressive response sets due to gender and culture-based differential item functioning." *Personality and Individual Differences* 33(6):937-954.

Lange, Rense. 2002. "Depressive Response Sets due to gender and culture-based Differential Item Functioning." *Personality and Individual Differences* 33(6):937-954

Latkin, Carl A. and Aaron D. Curry. 2003. "Stressful neighborhoods and depression: a prospective study of the impact of neighborhood disorder." *Journal of Health and Social Behavior*:34-44.

Leacock, Eleanor B. 1971. "The culture of poverty: A critique.". Simon and Schuster, New York, NY.

Lee, Barrett A., Sean F. Reardon, Glenn Firebaugh, Chad R. Farrell, Stephen A. Matthews and David O'Sullivan. 2008. "Beyond the census tract: Patterns and determinants of racial segregation at multiple geographic scales." *American Sociological Review* 73(5):766-791.

Lee, Dominic T. S., Joan Kleinman and Arthur Kleinman. 2007. "Rethinking Depression: An Ethnographic Study of the Experiences of Depression Among Chinese." *Harvard Review of Psychiatry* 15(1):1-8 .

Leo, J. 2004. "The biology of mental illness." *Society* 41(5):45-53.

Levine, R. S., J. E. Foster, R. E. Fullilove, M. T. Fullilove, N. C. Briggs, P. C. Hull, B. A. Husaini and C. H. Hennekens. 2001. "Black-white inequalities in mortality and life expectancy, 1933-1999: implications for healthy people 2010." *Public Health Reports* 116(5):474.

Lewis, Oscar. 1971. "The culture of poverty." *Poor Americans: How the White Poor Live*:20-26.

------. 1966. *La vida: a Puerto Rican family in the culture of poverty-San Juan and New York.* Random House New York.

Lewis-Fernandez, Roberto and Arthur Kleinman. 1995. "Cultural psychiatry: theoretical, clinical, and research issues." *Psychiatric Clinics of North America*.

Lincoln, Karen D., Linda M. Chatters and Robert J. Taylor. 2003. "Psychological distress among Black and White Americans: Differential effects of social support, negative interaction and personal control." *Journal of Health and Social Behavior* 44(3):390.

Livingston, Ivor L. 1994. *Handbook of Black American health: The mosaic of conditions, issues, policies, and prospects.* Greenwood Publishing Group.

Logan, John R., Brian J. Stults and Reynolds Farley. 2004. "Segregation of minorities in the metropolis: Two decades of change." *Demography* 41(1):1-22.

Longest, K. C. and P. A. Thoits. 2012. "Gender, the Stress Process, and Health: A Configurational Approach." *Society and Mental Health,* 2(3), 187-206.

Lynch, Elizabeth and Douglas Medin. 2006. "Explanatory models of illness: a study of within-culture variation." *Cognitive Psychology* 53(4):285-309.

Lynch, John W., George D. Smith, George A. Kaplan and James S. House. 2000. "Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions." *BMJ: British Medical Journal* 320(7243):1200.

Lynch, J. W., G. A. Kaplan, E. R. Pamuk, R. D. Cohen, K. E. Heck, J. L. Balfour and I. H. Yen. 1998. "Income inequality and mortality in metropolitan areas of the United States." *American Journal of Public Health* 88(7):1074-1080.

Macintyre, S. 2007. "Deprivation amplification revisited; or, is it always true that poorer places have poorer access to resources for healthy diets and physical activity?" *International Journal of Behavioral Nutrition and Physical Activity* 4(1):32.

Macintyre, S., A. Ellaway and S. Cummins. 2002. "Place effects on health: how can we conceptualise, operationalise and measure them?" *Social Science & Medicine* 55(1):125-139.

Macintyre, Sally and Anne Ellaway. 2003. "Neighborhoods and health: an overview." *Neighborhoods and Health*:20-42.

MacLeod, Jay. 1987. *Ain't no makin'it: Leveled aspirations in a low-income neighborhood.* Westview Press Boulder, CO.

Maillet, Nancya and Geralyn Spollett. 1996. "Using focus groups to characterize the health beliefs and practices of black women with non-insulin-dependent diabetes." *The Diabetes Educator* 22(1):39-46.

Marks, Loren, Olena Nesteruk, Mandy Swanson, Betsy Garrison and Tanya Davis. 2005. "Religion and Health Among African Americans A Qualitative Examination." *Research on Aging* 27(4):447-474.

Marks, Stephen R. 1977. "Multiple roles and role strain: Some notes on human energy, time and commitment." *American Sociological Review*:921-936.

Marmot, Michael. 2002. "The influence of income on health: views of an epidemiologist." *Health Affairs* 21(2):31-46.

Marsella, A. J. 2003. "Cultural aspects of depressive experience and disorders." *Online Readings in Psychology and Culture* 10(2):4.

Martin, J. K., B. A. Pescosolido and S. A. Tuch. 2000. "Of fear and loathing: The role of'disturbing behavior,'labels, and causal attributions in shaping public attitudes toward people with mental illness." *Journal of Health and Social Behavior*:208-223.

Martinez Tyson, Dinorah D., Heide Castañeda, Milagro Porter, Marisel Quiroz and Iraida Carrion. 2011. "More similar than different? Exploring cultural models of depression among Latino immigrants in Florida." *Depression Research and Treatment* 2011.

Maser, Jack D., Charles Kaelber and Richard E. Weise. 1991. "International use and attitudes toward DSM-III and DSM-III—R: Growing consensus in psychiatric classification." *Journal of Abnormal Psychology* 100(3):271.

Massey, D. S. 2001. "US Metropolitan Areas." *America Becoming: Racial Trends and their Consequences* 1:391.

Massey, Douglas S. 1990. "American apartheid: Segregation and the making of the underclass." *American Journal of Sociology*:329-357.

Matthews, Derrick D., Wizdom P. Hammond, Amani Nuru-Jeter, Yasmin Cole-Lewis and Travis Melvin. 2013. "Racial discrimination and depressive symptoms among African-American men: The mediating and moderating roles of masculine self-reliance and John Henryism." *Psychology of Men & Masculinity* 14(1):35.

Mattis, Jacqueline S. 2002. "Religion and spirituality in the meaning–making and coping experiences of African American women: A qualitative analysis." *Psychology of Women Quarterly* 26(4):309-321.

Maxwell, Joseph A. 1992. "Understanding and validity in qualitative research." *Harvard Educational Review* 62(3):279-301.

Mays, N. and C. Pope. 1995. "Qualitative research: Observational methods in health care settings." *BMJ: British Medical Journal* 311(6998):182.

Mays, Vickie M., Susan D. Cochran and Namdi W. Barnes. 2007. "Race, race-based discrimination, and health outcomes among African Americans." *Annu.Rev.Psychol.* 58:201-225.

McAlpine, D. D. and D. Mechanic. 2000. "Utilization of specialty mental health care among persons with severe mental illness: the roles of demographics, need, insurance, and risk." *Health Services Research* 35(1 Pt 2):277.

McAuley, William J., Loretta Pecchioni and Jo A. Grant. 2000. "Personal accounts of the role of God in health and illness among older rural African American and White residents." *Journal of Cross-Cultural Gerontology* 15(1):13-35.

McEwen, Bruce S. 2008. "Central effects of stress hormones in health and disease: Understanding the protective and damaging effects of stress and stress mediators." *European Journal of Pharmacology* 583(2):174-185.

------. 2007. "Physiology and neurobiology of stress and adaptation: central role of the brain." *Physiological Reviews* 87(3):873-904.

------. 1998. "Stress, adaptation, and disease: Allostasis and allostatic load." *Annals of the New York Academy of Sciences* 840(1):33-44.

McEwen, Bruce S. and Eliot Stellar. 1993. "Stress and the individual: mechanisms leading to disease." *Archives of Internal Medicine* 153(18):2093.

McGonagle, Katherine A. and Ronald C. Kessler. 1990. "Chronic stress, acute stress, and depressive symptoms." *American Journal of Community Psychology* 18(5):681-706.

McLeod, Jane D. 2012. "The Meanings of Stress Expanding the Stress Process Model." *Society and Mental Health* 2(3):172-186.

Mello, Andrea de Abreu Feijó de, Marcelo F. d. Mello, Linda L. Carpenter and Lawrence H. Price. 2003. "Update on stress and depression: the role of the hypothalamic-pituitary-adrenal (HPA) axis." *Revista Brasileira De Psiquiatria* 25(4):231-238.

Messner, Steven and Richard Rosenfeld. 2012. *Crime and the American dream.* Cengage Learning.

Mezzich, J. E., L. J. Kirmayer, A. Kleinman, H. Fabrega Jr, D. L. Parron, B. J. Good, K. M. Lin and S. M. Manson. 1999. "The place of culture in DSM-IV." *The Journal of Nervous and Mental Disease* 187(8):457.

Miles, M. B. and A. M. Huberman. 1994. *Qualitative data analysis: An expanded sourcebook.* Sage Publications, Incorporated.

Miller, Byron, Sunshine M. Rote and Verna M. Keith. 2013. "Coping with Racial Discrimination Assessing the Vulnerability of African Americans and the Mediated Moderation of Psychosocial Resources." *Society and Mental Health*.

Miller, Diane B. and James P. O'Callaghan. 2002. "Neuroendocrine aspects of the response to stress." *Metabolism* 51(6):5-10.

Mirowsky, John and Catherine E. Ross. 2002. "Measurement for a human science." *Journal of Health and Social Behavior*:152-170.

Mirzaei, M., C. Aspin, B. Essue, Y. H. Jeon, P. Dugdale, T. Usherwood and S. Leeder. 2013. "A patient-centred approach to health service delivery: improving health outcomes for people with chronic illness." *BMC Health Services Research* 13:251-6963-13-251.

Morrow, S. L. and M. L. Smith. 2000. "Qualitative research for counseling psychology.".

Mouzon, Dawne M. 2014. "Relationships of choice: Can friendships or fictive kinships explain the race paradox in mental health?" *Social Science Research* 44:32-43.

------. 2013. "Can Family Relationships Explain the Race Paradox in Mental Health?" *Journal of Marriage and Family* 75(2):470-485.

Mueller, Charles W. and Toby L. Parcel. 1981. "Measures of socioeconomic status: Alternatives and recommendations." *Child Development*:13-30.

Mulder, Roger T. 2008. "An epidemic of depression or the medicalization of distress?" *Perspectives in Biology and Medicine* 51(2):238-250.

Murray, C. J. L., S. C. Kulkarni, C. Michaud, N. Tomijima, M. T. Bulzacchelli, T. J. Iandiorio and M. Ezzati. 2006. "Eight Americas: investigating mortality disparities across races, counties, and race-counties in the United States." *PLoS Medicine* 3(9):e260.

Mustard, Cameron A., Marian Vermeulen and John N. Lavis. 2003. "Is position in the occupational hierarchy a determinant of decline in perceived health status?" *Social Science & Medicine* 57(12):2291-2303.

Myers, L. J., A. Young, E. Obasi and S. Speight. 2003. "Recommendations for the psychological treatment of persons of African descent." *Psychological Treatment of Ethnic Minority Populations*:13.

Myers, Margaret. 2000. "Qualitative research and the generalizability question: Standing firm with Proteus." *The Qualitative Report* 4(3/4):1-9.

Nastasi, Bonnie K. and Stephen L. Schensul. 2005. "Contributions of qualitative research to the validity of intervention research." *Journal of School Psychology* 43(3):177-195.

Neff, James A. 1984. "Race differences in psychological distress: the effects of SES, urbanicity, and measurement strategy." *American Journal of Community Psychology* 12(3):337-351.

Neighbors, Harold W., Rashid Njai and James S. Jackson. 2007. "Race, ethnicity, John Henryism, and depressive symptoms: The national survey of American life adult reinterview." *Research in Human Development* 4(1-2):71-87.

Newman, Katherine S. 2009. *No shame in my game: The working poor in the inner city*. Random House LLC, London.

Noh, Samuel and William R. Avison. 1996. "Asian immigrants and the stress process: A study of Koreans in Canada." *Journal of Health and Social Behavior*:192-206.

Nunnally, Shayla C. and Niambi M. Carter. 2012. "Moving from victims to victors: African American attitudes on the “culture of poverty” and black blame." *Journal of African American Studies* 16(3):423-455.

O’Brien, Kate, Michael Daffern, Chi M. Chu and Stuart D. Thomas. 2013. "Youth gang affiliation, violence, and criminal activities: A review of motivational, risk, and protective factors." *Aggression and Violent Behavior* 18(4):417-425.

Oakes, J. M. and Peter H. Rossi. 2003. "The measurement of SES in health research: current practice and steps toward a new approach." *Social Science & Medicine* 56(4):769-784.

Oliver, Melvin and Thomas Shapiro. 2006. *Black Wealth/White Wealth: A New Perspective on Racial Inequality 2E.* Routledge, New York.

Omi, Michael and Howard Winant. 2008. "Racial and Ethnic Formation." *Sociology: Exploring the Architecture of Everyday Life Readings*:269.

Ong, Anthony D., Thomas Fuller-Rowell and Anthony L. Burrow. 2009."Racial discrimination and the stress process." *Journal of Personality and Social Psychology* 96(6):1259.

Osypuk, Theresa L. and Dolores Acevedo-Garcia. 2010."Beyond individual neighborhoods: A geography of opportunity perspective for understanding racial/ethnic health disparities." *Health & Place* 16(6):1113-1123.

Owens, Pamela L., Kimberly Hoagwood, Sarah M. Horwitz, Philip J. Leaf, Jeanne M. Poduska, Sheppard G. Kellam and Nicholas S. Ialongo. 2002. "Barriers to children's mental health services." *Journal of the American Academy of Child & Adolescent Psychiatry* 41(6):731-738.

Pacheco, J., & Fletcher, J. 2014. Incorporating Health into Studies of Political Behavior Evidence for Turnout and Partisanship. *Political Research Quarterly*, 68(1), 104-116

Parker, M., L. Lee Roff, David L. Klemmack, Harold G. Koenig, P. Baker and Richard M. Allman. 2003. "Religiosity and mental health in southern, community-dwelling older adults." *Aging & Mental Health* 7(5):390-397.

Parkes, Katharine R. 1999. "Shiftwork, job type, and the work environment as joint predictors of health-related outcomes." *Journal of Occupational Health Psychology* 4(3):256.

Patel, V. and M.Winston. 1994. " Universality of mental illness" revisited: Assumptions, artefacts and new directions." *British Journal of Psychiatry*.165(4): 437-440

Payne, Yasser A. 2001."Black men and street life as a site of resiliency: A counter story for Black scholars." *International Journal of Critical Psychology* 4:109-122.

Payton, Andrew R. 2009. "Mental Health, Mental Illness, and Psychological Distress: Same Continuum or Distinct Phenomena?" *Journal of Health and Social Behavior* 50(2):213-227 HighWire Press.

Pearlin, L. I. 1989. "The sociological study of stress." *Journal of Health and Social Behavior*:241-256.

Pearlin, L. I., E. G. Menaghan, M. A. Lieberman and J. T. Mullan. 1981. "The stress process." *Journal of Health and Social Behavior*:337-356.

Pearlin, L. I. and C. Schooler. 1978. "The structure of coping." *Journal of Health and Social Behavior*:2-21.

Pearlin, Leonard I. 1999. "Stress and mental health: A conceptual overview." in A handbook for the study of mental health: Social contexts, theories, and systems. (pp. 161-175) Horwitz, Allan V. (Ed); Scheid, Teresa L. (Ed), (1999), Cambridge University Press, New York, NY, US

------. 1993. "The social contexts of stress." in Handbook of stress: Theoretical and clinical aspects (2nd ed.) (pp. 303-315). Goldberger, Leo (Ed); Breznitz, Shlomo (Ed), Free press, New York, NY.

Pearlin, Leonard I., Carol S. Aneshensel and Allen J. Leblanc. 1997. "The forms and mechanisms of stress proliferation: The case of AIDS caregivers." *Journal of Health and Social Behavior*:223-236.

Pearlin, Leonard I., Joseph T. Mullan, Shirley J. Semple and Marilyn M. Skaff. 1990. "Caregiving and the stress process: An overview of concepts and their measures." *The Gerontologist* 30(5):583-594.

Pearlin, Leonard I., Scott Schieman, Elena M. Fazio and Stephen C. Meersman. 2005. "Stress, health, and the life course: Some conceptual perspectives." *Journal of Health and Social Behavior* 46(2):205-219.

Peng, Kaiping, Richard E. Nisbett and Nancy Y. Wong. 1997. "Validity problems comparing values across cultures and possible solutions." *Psychological Methods* 2(4):329.

Petterson, Stephen M. 1997. "Are young black men really less willing to work?" *American Sociological Review*:605-613.

Pettit, B. and B. Western. 2004. "Mass imprisonment and the life course: Race and class inequality in US incarceration." *American Sociological Review* 69(2):151-169.

Pham-Kanter, Genevieve. 2009. "Social comparisons and health: Can having richer friends and neighbors make you sick?" *Social Science & Medicine* 69(3):335-344.

Pilgrim, D. 2002. "The biopsychosocial model in Anglo-American psychiatry: Past, present and future?" *Journal of Mental Health* 11(6):585-594.

Pillow, David R., Alex J. Zautra and Irwin Sandler. 1996. "Major life events and minor stressors: Identifying mediational links in the stress process." *Journal of Personality and Social Psychology* 70(2):381.

Pinquart, Martin and Silvia Sörensen. 2003. "Associations of stressors and uplifts of caregiving with caregiver burden and depressive mood: a meta-analysis." *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 58(2):P112-P128.

Plant, E. A. and Natalie Sachs-Ericsson. 2004. "Racial and ethnic differences in depression: the roles of social support and meeting basic needs." *Journal of Consulting and Clinical Psychology* 72(1):41.

Pollner, Melvin and Robert M. Emerson. 2001. "Ethnomethodology and ethnography." *Handbook of Ethnography*:118-135.

Popa, Bogdan, Laurent Guillet and Etienne Mullet. 2014. "Cultural differences in the appraisal of stress." *Psicológica* 35(3):745-760.

Poussaint, A. and A. Alexander. 2000. "Lay my burden down." Beacon Pr.., Boston.

Pudrovska, T., S. Schieman, L. I. Pearlin and K. Nguyen. 2005. "The sense of mastery as a mediator and moderator in the association between economic hardship and health in late life." *Journal of Aging and Health* 17(5):634-660.

Quillian, L. and D. Pager. 2001. "Black Neighbors, Higher Crime? The Role of Racial Stereotypes in Evaluations of Neighborhood Crime1." *American Journal of Sociology* 107(3):717-767.

Quimby, Ernest. 2006. "Ethnography's role in assisting mental health research and clinical practice." *Journal of Clinical Psychology* 62(7):859-879.

Rao, Deepa, Joseph Feinglass and Patrick Corrigan. 2007. "Racial and ethnic disparities in mental illness stigma." *The Journal of Nervous and Mental Disease* 195(12):1020-1023.

Richards, T., A. Coulter and P. Wicks. 2015. "Time to deliver patient centred care." *BMJ (Clinical Research Ed.)* 350:h530.

Rios, Rebeca, Leona S. Aiken and Alex J. Zautra. 2012. "Neighborhood contexts and the mediating role of neighborhood social cohesion on health and psychological distress among Hispanic and non-Hispanic residents." *Annals of Behavioral Medicine* 43(1):50-61.

Robins, Lee N. and Darrel A. Regier. 1991. *Psychiatric disorders in America: the epidemiologic catchment area study.* Free Press.

Romney, A. K. 1999. "Culture consensus as a statistical model." *Current Anthropology* 40:S103-S115.

Romney, A. K., Susan C. Weller and William H. Batchelder. 1986. "Culture as consensus: A theory of culture and informant accuracy." *American Anthropologist* 88(2):313-338.

Rosenbaum, James E. 1995. "Changing the geography of opportunity by expanding residential choice: Lessons from the Gautreaux program." *Housing Policy Debate* 6(1):231-269.

Rosenberg, M. 1965. "The measurement of self-esteem." *Society and the Adolescent Self Image*:297-307.

Rosenfield, S., M. C. Lennon and H. R. White. 2005. "The self and mental health: Self-salience and the emergence of internalizing and externalizing problems." *Journal of Health and Social Behavior* 46(4):323-340.

Rosenfield, S. 2012. "Triple jeopardy? Mental health at the intersection of gender, race, and class." *Social Science Medicine* 74(11):1791

Ross, C. E. 2000. "Neighborhood disadvantage and adult depression." *Journal of Health and Social Behavior*:177-187.

Ross, C. E. and C. L. Wu. 1996. "Education, age, and the cumulative advantage in health." *Journal of Health and Social Behavior*:104-120.

Ross, C. E. and J. Mirowsky. 2009. "Neighborhood disorder, subjective alienation, and distress." *Journal of Health and Social Behavior* 50(1):49-64.

Roxburgh, S. 2009. "Untangling Inequalities: Gender, Race, and Socioeconomic Differences in Depression." 24(2):357-381.

Sachs-Ericsson, N., EA Plant and DG Blazer. 2005. "Racial differences in the frequency of depressive symptoms among community dwelling elders: the role of socioeconomic factors." *Aging & Mental Health* 9(3):201-209.

Safford, Monika M., Todd M. Brown, Paul M. Muntner, Raegan W. Durant, Stephen Glasser, Jewell H. Halanych, James M. Shikany, Ronald J. Prineas, Tandaw Samdarshi and Vera A. Bittner. 2012. "Association of Race and Sex With Risk of Incident Acute Coronary Heart Disease EventsIncident Acute Coronary Heart Disease Events." *JAMA* 308(17):1768-1774.

Sam, D., V. Moreira, W. Lonner, D. Dinnel, S. Hayes, D. Sattler 2002. "The mutual embeddedness of culture and mental illness." *Online Readings in Psychology and Culture*.

Sampson, Robert J., Jeffrey D. Morenoff and Thomas Gannon-Rowley. 2002. "Assessing" neighborhood effects": Social processes and new directions in research." *Annual Review of Sociology*:443-478.

Sampson, Robert J., Stephen W. Raudenbush and Felton Earls. 1997. "Neighborhoods and violent crime: A multilevel study of collective efficacy." *Science* 277(5328):918-924.

Sanday, Peggy R. 1979. "The ethnographic paradigm (s)." *Administrative Science Quarterly* 24(4):527-538.

Sandelowski, Margarete. 1995. "Sample size in qualitative research." *Research in Nursing & Health* 18(2):179-183.

Sapolsky, Robert M., L. M. Romero and Allan U. Munck. 2000. "How do glucocorticoids influence stress responses? Integrating permissive, suppressive, stimulatory, and preparative actions." *Endocrine Reviews* 21(1):55-89.

Scheff, Thomas. 2013. "Diagnosis as Part of a Large Social Emotional System." *Deviant Behavior* 34(12):991-995.

Scheff, Thomas J. 2005. "Looking-Glass Self: Goffman as Symbolic Interactionist." *Symbolic Interaction* 28(2):147-166.

Schieman, S., T. Pudrovska, L. I. Pearlin and C. G. Ellison. 2006. "The sense of divine control and psychological distress: Variations across race and socioeconomic status." *Journal for the Scientific Study of Religion* 45(4):529-549.

Schieman, Scott and Leonard I. Pearlin. 2006. "Neighborhood disadvantage, social comparisons, and the subjective assessment of ambient problems among older adults." *Social Psychology Quarterly* 69(3):253-269.

Schieman, S., L. I. Pearlin and S. C. Meersman. 2006. "Neighborhood disadvantage and anger among older adults: social comparisons as effect modifiers." *Journal of Health and Social Behavior* 47(2):156-172.

Schieman, Scott. 2008. "The Education-Contingent Association between Religiosity and Health: The Differential Effects of Self-Esteem and the Sense of Mastery." *Journal for the Scientific Study of Religion* 47(4):710-724

Schlenker, Barry R. 1980. *Impression management: The self-concept, social identity, and interpersonal relations.* Brooks/Cole Publishing Company Monterey, CA.

Schnittker, J. 2012. "The Proximity of Common Unhappiness and Misery." *Society and Mental Health*. 2 (3): 135-153.

------. 2008. "An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance." *Social Science & Medicine* 67(9):1370-1381.

------. 2003. "Misgivings of Medicine?: African Americans' Skepticism of Psychiatric Medication." *Journal of Health and Social Behavior* 44(4):506-524

Schnittker, J., J. Freese and B. Powell. 1999. "Nature, nurture, neither, nor: Black-White differences in beliefs about the cause and appropriate treatment of mental illness." *Soc.F.* 78:1101.

Schofield, Janet W. 2002. "Increasing the generalizability of qualitative research." *The Qualitative Researcher's Companion*:171-203.

Schulz, Amy, Barbara Israel, David Williams, Edith Parker, Adam Becker and Sherman James. 2000. "Social inequalities, stressors and self-reported health status among African American and white women in the Detroit metropolitan area." *Social Science & Medicine* 51(11):1639-1653.

Schwartz, Shalom H. 1994. "Are there universal aspects in the structure and contents of human values?" *Journal of Social Issues* 50(4):19-45.

Schwartz, S. 2007. "Distinguishing distress from disorder as psychological outcomes of stressful social arrangements: can we and should we?" *Health (London, England : 1997)* 11(3):291-9; discussion 321-6.

Selby, Joe V., Anne C. Beal and Lori Frank. 2012. "The Patient-Centered Outcomes Research Institute (PCORI) national priorities for research and initial research agenda." *JAMA* 307(15):1583-1584.

Sellers, Robert M., Cleopatra H. Caldwell, Karen H. Schmeelk-Cone and Marc A. Zimmerman. 2003. "Racial identity, racial discrimination, perceived stress, and

psychological distress among African American young adults." *Journal of Health and Social Behavior*:302-317.

Sellers, Sherrill L., Harold W. Neighbors and Vence L. Bonham. 2011. "Goal-Striving Stress and the Mental Health of College-Educated Black American Men: The Protective Effects of System-Blame." *American Journal of Orthopsychiatry* 81(4):507-518.

Shap, Kacey. 2014. "Island in the street: analyzing the function of gang violence from a culture and conflict perspective." *Journal of Aggression, Conflict and Peace Research* 6(2):78-98.

Shapiro, Thomas M. and Jessica L. Kenty-Drane. 2005. "The racial wealth gap." *African Americans in the US Economy*:175-181.

Shaun, R. and H. Andrew. 2008. "Are they not all the same? Racial heterogeneity among Black male undergraduates." *Journal of College Student Development* 49:247-269.

Shavers, Vickie L. 2007. "Measurement of socioeconomic status in health disparities research." *Journal of the National Medical Association* 99(9):1013.

Shaw, Susan J., Cristina Huebner, Julie Armin, Katherine Orzech and James Vivian. 2009. "The role of culture in health literacy and chronic disease screening and management." *Journal of Immigrant and Minority Health* 11(6):460-467.

Shonkoff, Jack P., W. T. Boyce and Bruce S. McEwen. 2009. "Neuroscience, molecular biology, and the childhood roots of health disparities." *JAMA: The Journal of the American Medical Association* 301(21):2252-2259.

Shorter-Gooden, Kumea. 2004. "Multiple resistance strategies: How African American women cope with racism and sexism." *Journal of Black Psychology* 30(3):406-425.

Shuey, Kim M. and Andrea E. Willson. 2008. "Cumulative disadvantage and black-white disparities in life-course health trajectories." *Research on Aging* 30(2):200-225.

Silva de Crane. 1981. "Attitudes of Hispanic, Black, and Caucasian university students toward mental illness." *Hispanic Journal of Behavioral Sciences* 3(3):241.

Simning, Adam, Edwin van Wijngaarden and Yeates Conwell. 2012. "The association of African Americans' perceptions of neighborhood crime and drugs with mental illness." *Social Psychiatry and Psychiatric Epidemiology* 47(7):1159-1167.

Small, Mario L. and Katherine Newman. 2001. "Urban poverty after the truly disadvantaged: The rediscovery of the family, the neighborhood, and culture." *Annual Review of Sociology*:23-45.

Smith, James P. and Raynard Kington. 1997. "Demographic and economic correlates of health in old age." *Demography* 34(1):159-170.

Snowden, L. R. 1999. "African American folk idiom and mental health services use." *Cultural Diversity and Ethnic Minority Psychology* 5(4):364.

Somervell, Philip D., Philip J. Leaf, Myrna M. Weissman, Dan G. Blazer and Martha L. Bruce. 1989. "The prevalence of major depression in black and white adults in five United States communities." *American Journal of Epidemiology* 130(4):725-735.

Spradley, James P. 1980. "Participant observation." Holt, Rinehart and Winston, New York, NY

Sroufe, L. A., S. Duggal, N. Weinfield and E. Carlson. 2000. "Relationships, development, and psychopathology." *Handbook of Developmental Psychopathology* 2:75-91.

Sterling, Peter. 2004. "Principles of allostasis: optimal design, predictive regulation, pathophysiology, and rational therapeutics." *Allostasis*.

Stewart, James A. 2006. "The detrimental effects of allostasis: allostatic load as a measure of cumulative stress." *Journal of Physiological Anthropology* 25(1):133-145.

Stockdale, Susan E., Kenneth B. Wells, Lingqi Tang, Thomas R. Belin, Lily Zhang and Cathy D. Sherbourne. 2007. "The importance of social context: neighborhood stressors, stress-buffering mechanisms, and alcohol, drug, and mental health disorders." *Social Science & Medicine* 65(9):1867-1881.

Subramanian, SV, Dolores Acevedo-Garcia and Theresa L. Osypuk. 2005. "Racial residential segregation and geographic heterogeneity in black/white disparity in poor self-rated health in the US: a multilevel statistical analysis." *Social Science & Medicine* 60(8):1667-1679.

Subramanian, SV, & Perkins, JM. 2010. Are republicans healthier than democrats?. *International Journal of Epidemiology*, 39(3), 930-931.

Swidler, Ann. 1986. "Culture in action: Symbols and strategies." *American Sociological Review*:273-286.

Szanton, Sarah L., Jessica M. Gill and Jerilyn K. Allen. 2005. "Allostatic load: a mechanism of socioeconomic health disparities?" *Biological Research for Nursing* 7(1):7-15.

Taylor, Jerome, Delores Henderson and Beryl B. Jackson. 1991. "A holistic model for understanding and predicting depressive symptoms in African-American women." *Journal of Community Psychology* 19(4):306-320.

Taylor, Jerome and Beryl Jackson. 1990. "Factors affecting alcohol consumption in black women. Part II." *Substance use & Misuse* 25(12):1415-1427.

Taylor, John and R. J. Turner. 2002. "Perceived discrimination, social stress, and depression in the transition to adulthood: Racial contrasts." *Social Psychology Quarterly*:213-225.

Taylor, Lorraine C. 2001. "Work attitudes, employment barriers, and mental health symptoms in a sample of rural welfare recipients." *American Journal of Community Psychology* 29(3):443-463.

Taylor, S. E. and A. L. Stanton. 2007. "Coping resources, coping processes, and mental health." *Annu.Rev.Clin.Psychol.* 3:377-401.

Taylor, R. J., L. M. Chatters and J. S. Jackson. 2007. "Religious and spiritual involvement among older African Americans, Caribbean blacks, and non-Hispanic whites: findings from the National Survey of American life." *The Journals of Gerontology.Series B, Psychological Sciences and Social Sciences* 62(4):S238-50.

Terry, Deborah J., Michael A. Hogg and Katherine M. White. 1999. "The theory of planned behaviour: self-identity, social identity and group norms." *British Journal of Social Psychology* 38(3):225-244.

Thakker, Joanne and Tony Ward. 1998. "Culture and classification: The cross-cultural application of the DSM-IV." *Clinical Psychology Review* 18(5):501-529.

Thoits, P. A. 2010. "Stress and Health Major Findings and Policy Implications." *Journal of Health and Social Behavior* 51(1 suppl):S41-S53.

------. 1994. "Stressors and problem-solving: The individual as psychological activist." *Journal of Health and Social Behavior*:143-160.

Thoits, Peggy A. 1995. "Stress, coping, and social support processes: Where are we? What next?" *Journal of Health and Social Behavior*:53-79.

------. 1986. "Social support as coping assistance." *Journal of Consulting and Clinical Psychology* 54(4):416.

Thomas, Stephen B., Michael J. Fine and Said A. Ibrahim. 2004. "Health disparities: the importance of culture and health communication." *American Journal of Public Health* 94(12):2050.

Thompson, V. L. S., A. Bazile and M. Akbar. 2004. "African Americans' perceptions of psychotherapy and psychotherapists." *Professional Psychology: Research and Practice* 35(1):19.

Tropp, Linda R. and Stephen C. Wright. 1999. "Ingroup identification and relative deprivation: An examination across multiple social comparisons." *European Journal of Social Psychology* 29(5-6):707-724.

Tsigos, Constantine and George P. Chrousos. 2002. "Hypothalamic–pituitary–adrenal axis, neuroendocrine factors and stress." *Journal of Psychosomatic Research* 53(4):865-871.

Turner, R. J. 1999. "Social support and coping.".

Turner, R. J. and Donald A. Lloyd. 1999. "The stress process and the social distribution of depression." *Journal of Health and Social Behavior*:374-404.

Turner, R. J. and Blair Wheaton. 1995. "Checklist measurement of stressful life events." *Measuring Stress: A Guide for Health and Social Scientists*:29-58.

Turner, R. J. and D. W. Wood. 1985. "Depression and disability: The stress process in a chronically strained population." *Research in Community & Mental Health*.

Turner, R. J. and W. R. Avison. 2003. "Status variations in stress exposure: Implications for the interpretation of research on race, socioeconomic status, and gender." *Journal of Health and Social Behavior*:488-505.

------. 1992. "Innovations in the measurement of life stress: Crisis theory and the significance of event resolution." *Journal of Health and Social Behavior*:36-50.

Turner, R. J. and P. Roszell. 1994. "Psychosocial resources and the stress process." *Stress and Mental Health: Contemporary Issues and Prospects for the Future*:179-210.

Tynes, B. M., S. O. Utsey and H. A. Neville. 2008. *Handbook of African American Psychology.* Sage Publications, Thousand Oaks, CA.

Tyrer, P. and D. Steinberg. 2006. *Models for mental disorder.* Wiley, Hoboken, NJ.

Underwood, J. M., Julie S. Townsend, Eric Tai, Shane P. Davis, Sherri L. Stewart, Arica White, Behnoosh Momin and Temeika L. Fairley. 2012. "Racial and regional disparities in lung cancer incidence." *Cancer* 118(7):1910-1918.

Valentine, Charles A. 1968. "Culture and poverty; critique and counter-proposals.".

van de Vijver, Fons JR, Athanasios Chasiotis and Seger M. Breugelmans. 2011. *Fundamental questions in cross-cultural psychology.* Cambridge University Press.

Venkatesh, Sudhir A. 2013. "The Reflexive Turn: The Rise of First-Person Ethnography." *The Sociological Quarterly* 54(1):3-8.

von Hippel, William, Courtney von Hippel, Leanne Conway, Kristopher J. Preacher, Jonathan W. Schooler and Gabriel A. Radvansky. 2005. "Coping with stereotype threat: denial as an impression management strategy." *Journal of Personality and Social Psychology* 89(1):22.

Wacquant, Loïc. 2003. "Ethnografeast A Progress Report on the Practice and Promise of Ethnography." *Ethnography* 4(1):5-14.

------. 2002. "Scrutinizing the Street: Poverty, Morality, and the Pitfalls of Urban Ethnography1." *American Journal of Sociology* 107(6):1468-1532.

Wainberg, Milton. 2007. "Targeted ethnography as a critical step to inform cultural adaptations of HIV prevention interventions for adults with severe mental illness." *Social Science Medicine* 65(2):296-308.

Waitzkin, Howard and Holly Magana. 1997. "The black box in somatization: unexplained physical symptoms, culture, and narratives of trauma." *Social Science & Medicine* 45(6):811-825.

Wakefield, Jerome C. 1992. "Disorder as harmful dysfunction: a conceptual critique of DSM-III-R's definition of mental disorder." *Psychological Review* 99(2):232.

Wakefield, Jerome C., Kathleen J. Pottick and Stuart A. Kirk. 2002. "Should the DSM-IV diagnostic criteria for conduct disorder consider social context?" *American Journal of Psychiatry* 159(3):380-386.

Wallace, Maeve, Emily Harville, Katherine Theall, Larry Webber, Wei Chen and Gerald Berenson. 2013. "Neighborhood poverty, allostatic load, and birth outcomes in African American and white women: Findings from the Bogalusa Heart Study." *Health & Place* 24:260-266.

Wandersman, Abraham and Maury Nation. 1998. "Urban neighborhoods and mental health: Psychological contributions to understanding toxicity, resilience, and interventions." *American Psychologist* 53(6):647.

Wang, Philip S., Michael Lane, Mark Olfson, Harold A. Pincus, Kenneth B. Wells and Ronald C. Kessler. 2005. "Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication." *Archives of General Psychiatry* 62(6):629.

Ward-Colasante, Carol and J. ohn Farmer. 1993. "of Drop-In Centers Operated by Mental Health Consumers." *Hospital and Community Psychiatry* 44(7):675.

Ware, N. C., T. Tugenberg, B. Dickey and C. A. McHorney. 1999. "An ethnographic study of the meaning of continuity of care in mental health services." *Psychiatric Services* 50(3):395-400.

Washington, A. E. and Steven H. Lipstein. 2011. "The Patient-Centered Outcomes Research Institute—promoting better information, decisions, and health." *New England Journal of Medicine* 365(15).

Weissman, Myrna M., Martha L. Bruce, Philip J. Leaf, Louise P. Florio and Ch Holzer. 1991. "Affective disorders." *Psychiatric Disorders in America*:53-80.

Weisz, John R. and Bahr Weiss. 1991. "Studying the" referability" of child clinical problems." *Journal of Consulting and Clinical Psychology* 59(2):266.

Weller, Susan C. 2007. "Cultural consensus theory: Applications and frequently asked questions." *Field Methods* 19(4):339-368.

Weller, Susan C. and A. K. Romney. 1988. *Systematic data collection.* Sage.

Wen, Ming, Louise C. Hawkley and John T. Cacioppo. 2006. "Objective and perceived neighborhood environment, individual SES and psychosocial factors, and self-rated health: An analysis of older adults in Cook County, Illinois." *Social Science & Medicine* 63(10):2575-2590.

Wethington, Elaine, George W. Brown and Ronald C. Kessler. 1995. "Interview measurement of stressful life events." *Measuring Stress: A Guide for Health and Social Scientists*:59-79.

Whaley, Arthur L. 1998. "Cross-cultural perspective on paranoia: A focus on the Black American experience." *Psychiatric Quarterly* 69(4):325-343.

Wheaton, Blair. 2010. "The stress process as a successful paradigm." Pp. 231-252 in *Advances in the Conceptualization of the Stress Process*"The stress process as a successful paradigm."Springer.

------. 1999. "The nature of stressors." in A Handbook for the Study of Mental Health Pp. 176-197) edited by Alan Horwitz and Teresa Scheid. Cambridge University Press, Cambridge and New York.

Wheaton, Blair, Marisa Young, Shirin Montazer and Katie Stuart-Lahman. 2013. "Social stress in the twenty-first century." Pp. 299-323 in *Handbook of the sociology of mental health*"Social stress in the twenty-first century."Springer.

Wheaton, B. 2007. "The twain meet: distress, disorder and the continuing conundrum of categories (comment on Horwitz)." *Health (London, England : 1997)* 11(3):303-19; discussion 321-326.

Whitehead, Tony L. 2005. "Basic classical ethnographic research methods." *Ethnographically Informed Community and Cultural Assessment Research Systems: Working Paper Series.Maryland: Cultural Ecology of Health and Change.*

Whitley, R. and M. Crawford. 2005. "Qualitative research in psychiatry." *Canadian Journal of Psychiatry* 50(2):108-114.

Whooley, O. 2010. "Diagnostic ambivalence: Psychiatric workarounds and the diagnostic and statistical manual of mental disorders." *Sociology of Health & Illness* 32(3):452-469.

Wight, R. G., C. S. Aneshensel, C. Barrett, M. Ko, J. Chodosh and A. S. Karlamangla. 2013. "Urban neighbourhood unemployment history and depressive symptoms over time among late middle age and older adults." *Journal of Epidemiology and Community Health* 67(2):153-158.

Williams, D. R. and C. Collins. 2001a. "Racial residential segregation: a fundamental cause of racial disparities in health." *Public Health Reports* 116(5):404.

Williams, D. R. and T. R. Earl. 2007. "Commentary: Race and mental health—More questions than answers." *International Journal of Epidemiology* 36(4):758-760.

Williams, D. R., H. M. Gonzalez, H. Neighbors, R. Nesse, J. M. Abelson, J. Sweetman and J. S. Jackson. 2007. "Prevalence and distribution of major depressive disorder in African Americans, Caribbean blacks, and non-Hispanic whites: results from the National Survey of American Life." *Archives of General Psychiatry* 64(3):305.

Williams, D. R. and R. Williams-Morris. 2000. "Racism and mental health: The African American experience." *Ethnicity & Health*. 5(3-4), 243-268.

Williams, D. R., Y. Yu, J. S. Jackson and N. B. Anderson. 1997. "Racial differences in physical and mental health." *Journal of Health Psychology* 2(3):335-351.

Williams, David R. 2012. "Miles to Go before We Sleep Racial Inequities in Health." *Journal of Health and Social Behavior* 53(3):279-295.

------. 2005. "The health of US racial and ethnic populations." *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 60(Special Issue 2):S53-S62.

Williams, David R. and Chiquita Collins. 2001b. "Racial residential segregation: a fundamental cause of racial disparities in health." *Public Health Reports* 116(5):404.

------. 1995. "US socioeconomic and racial differences in health: patterns and explanations." *Annual Review of Sociology*:349-386.

Williams, David R. and Pamela B. Jackson. 2005. "Social sources of racial disparities in health." *Health Affairs* 24(2):325-334.

Williams, David R., Risa Lavizzo-Mourey and Rueben C. Warren. 1994. "The concept of race and health status in America." *Public Health Reports* 109(1):26.

Williams, David R. and Selina A. Mohammed. 2009. "Discrimination and racial disparities in health: evidence and needed research." *Journal of Behavioral Medicine* 32(1):20-47.

Williams, David R., Selina A. Mohammed, Jacinta Leavell and Chiquita Collins. 2010. "Race, socioeconomic status, and health: complexities, ongoing challenges, and research opportunities." *Annals of the New York Academy of Sciences* 1186(1):69-101.

Williams, D. R. 2003. "The health of men: structured inequalities and opportunities." *American Journal of Public Health* 93(5):724-731.

Williams, D. R., H. W. Neighbors and J. S. Jackson. 2003. "Racial/ethnic discrimination and health: findings from community studies." *American Journal of Public Health* 93(2):200-208.

Wilson, William J. 2009. *More than just race: Being black and poor in the inner city (issues of our time).* WW Norton & Company.

Wilson, William J. 2010. "Why both social structure and culture matter in a holistic analysis of inner-city poverty." *The Annals of the American Academy of Political and Social Science* 629(1):200-219.

Wilson, William J. and Leslie Dunbar. 1984. "The urban underclass." *Minority Report: What Happens to Blacks, Hispanics, American Indians and Other Minorities in the Eighties*.

Winkleby, M. A., D. E. Jatulis, E. Frank and S. P. Fortmann. 1992. "Socioeconomic status and health: how education, income, and occupation contribute to risk factors for cardiovascular disease." *American Journal of Public Health* 82(6):816-820.

Wolcott, Harry F. 2005. *The art of fieldwork.* Rowman Altamira.

------. 1987. "On ethnographic intent." *Interpretive Ethnography of Education: At Home and Abroad*:37-57.

Wood, Joanne V. 1996. "What is social comparison and how should we study it?" *Personality and Social Psychology Bulletin* 22(5):520-537.

------. 1989. "Theory and research concerning social comparisons of personal attributes." *Psychological Bulletin* 106(2):231.

ya Azibo, D. A. 1989. "African-centered theses on mental health and a nosology of Black/African personality disorder." *Journal of Black Psychology* 15(2):173-214.

Young, Alford A. 2013. "Uncovering a Hidden “I” in Contemporary Urban Ethnography." *The Sociological Quarterly* 54(1):51-65.

------. 2006. *The minds of marginalized black men: Making sense of mobility, opportunity, and future life chances.* Princeton University Press.

Zhang, Amy Y. and Lonnie R. Snowden. 1999. "Ethnic characteristics of mental disorders in five US communities." *Cultural Diversity and Ethnic Minority Psychology* 5(2):134.

APPENDICES

APPENDIX A: Guide for eliciting cultural information on components of the stress process		
Component of the stress process	**Cultural Concepts**	**Measures**
Stressors	Stress exposure	Sources of stress and strains that are observed and that come up in conversations. For example unemployment, demands that cannot be met with existing resources, daily hassles like public transportation problems. Stressful events cited in conversations. Frequency of stressful events, distribution of stressors.
	Appraisal of stress and stressors	The level or degree to which people judge stressful events, strains and daily hassles as "stressful". Assessments of the significance and manageability of stressful events as they happen, or stressors mentioned in conversation. For example, in a conversation about high crime rates, the following questions may elicit responses that address appraisal of high crime as a stressor. How much time do you spend thinking about your safety? Do you feel anxious when you have to go to the grocery store at night? Can something be done about discrimination you face at work or is it a lost cause?
Resources	Coping mechanisms and stress-reducing resources	Mentions, observations and conversations about the ways of dealing with stressors. Culturally acceptable ways of overcoming difficulties. For example, identifying things that people usually do or ask others to do to help relax during daily hassles or during stressful events such as job loss. A question such as: How did you guys survive the last tornado? may elicit responses that identify and shed light on how values such as collectivism and spirituality increase coping ability. Behavioral or cognitive responses - Denial or minimization- a conscious effort to ignore the stressor. In a conversation about a significant stressor the following statement may indicate minimization: "It is a big problem but we try not to dwell on it." Range of resources - Discussions about the resources that people use when exposed to stressors or things that help prepare them to deal with stress. For example, events, organizations, institutions, people, certain values or beliefs about life in general.

Stress outcomes	Symptoms and expression of distress	Mentions and conversations about mental health problems. Identifying what people consider to be psychiatric distress. For example, a recent arrest from substance use may lead to conversations about mental health. A remark such as: “I wonder whether his drug use is related to mental health problems” may illicit discussion around common signs and symptoms of distress.
	Somatization and externalization	Mentions and conversations about physical and behavioral reactions to stress. For example, chest or stomach pain, fighting, drug use.
	Perceptions of distress	Observations, mentions and discussions around stigma, perceptions of other people with mental health problems.

APPENDIX B CONSENT FORM

Culture and Mental Health among African Americans

You are invited to be in a research study that aims to understand how culture influences stress, ways by which stress is dealt with, and the meaning of mental health in the African American community. You were selected as a possible participant because you live in this neighborhood, and because of your knowledge about African American life. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Sirry Alang, a doctoral student in Health Services Research at the University of Minnesota.

Background Information
The purpose of this study is to describe how cultural factors influence stress, ways of dealing with stress, and the meaning of mental health in the African American community. It is being done as part of my dissertation work at the School of Public Health, University of Minnesota.

Procedures
If you agree to be in this study, we would ask you to answer questions on this survey. The survey will not take you longer than ten minutes to complete.

Risks and Benefits of being in the Study
Participation may lead to sharing of information that you might consider personal. There are no direct benefits for participating in the study.

Compensation
You will not receive any payment.

Confidentiality and Privacy
The survey does not ask you for your name or other personal identifying information. The results will not include any information that will make it possible to identify a participant. Research information will be stored securely and only researchers will have access to the records.

Voluntary Nature of the Study:
Participation in this study is voluntary. You may choose not to answer any question. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota.

Contacts and Questions:
The researcher conducting this study is Sirry Alang and her advisor is Dr. Donna McAlpine. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact them at:

Division of Health Policy & Management,
420 Delaware Street SE, 15-232 PWB
Minneapolis MN
Phone: 612-625-9919
Emails: alang002@umn.edu (Sirry) and mcalp004@umn.edu (Dr. McAlpine)

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

Provide a copy of this information to keep for your records

APPENDIX C: SURVEY

Part 1: Below is a list of things that cause stress. Thinking about the African American community, how important are each of the following as sources of stress?

Items	Not Important	Somewhat Important	Very Important
Gun violence			
Poor housing conditions			
Isolation from resources			
Racial stereotyping			
Poverty			
Presence of drug dealers			
Unemployment			
Suspicion from police			
Pressure to be strong/come out on the other side			
Unfair treatment by law enforcement			
Homicides			
Grief from loss of loved ones			
Difficulty meeting your responsibilities and obligations			
Being taken advantage of because of race			
Incarcerations			
Lack of opportunities to improve quality of life			
Underfunded services			
Lack of confidence in the government			
Employment discrimination			
Homelessness			
Robberies			

Part 2: Below is a list of ways in which people respond to stress, or things they do when they are stressed. Thinking about the African American community, how important are each of the following for dealing with stress? Don't worry about whether any of these ways of dealing with stress are good or bad.

Items	Not Important	Somewhat Important	Very Important
Praying			
Playing sports			
Money			
Drugs and alcohol			
Open door policy with family and friends			
Comfort food			
Friends and family			
Being hopeful			
Acting like the problem doesn't matter /hurt			
Perseverance			
Rap music			
Church			
Behaving like everything is going well			
Maintaining a positive mindset			
Self-confidence			
Black community solidarity			
Having faith			
Being assertive/standing up for yourself			
Meditation			
Frequent family get together			
Working hard			
Gang membership			
Joining social groups			
Having control over your life			
Pressing on even when it is hard			

Part 3: Below is a list of words or phrases that come to mind when people hear about mental health problems, or that have been used to describe people who have mental health problems. Thinking about the African American community, how common are each of the following for indicating mental health problems?

Items	Not Common	Somewhat Common	Very Common
Crazy			
Obsessing about everything			
Crying			
Nervous			
Severe depression			
Unpredictable			
Physical aggression/hostility			
Sick			
Feeling shook			
Flashbacks			
Temper outbursts			
Unreliable			
Agitation			
Fearful			
Inability to cope with anything			
Weak			

Part 4: Below is a list of words or phrases that come to mind when people hear about depression, or that have been used to describe people who have had depression. Thinking about the African American community, how important are each of the following items for indicating depression?

Items from the word listing exercise	Not Important	Somewhat Important	Very Important
Having the blues			
Low self-esteem			
Self-isolation			
Hopelessness			
Extreme sadness			
Irrational, dangerous and violent behavior			
Not knowing what to do next			
Weakness/having a weak mind			
Crying			
A weight on the mind that won't shake			
Not dependable			
Rage and anger			
Agitation			
Lack of motivation/interest			
Having a heavy heart			
Moody			
Overeating			
Sleeping too much			
Heaving feeling in legs			
Too much socializing and going out			
Bad nerves			
Loss of appetite			
Paranoia			
Sleeplessness			

Part 5: Please answer the following questions:

1) What is your gender (circle one)? Man Woman
   Other_____

2) How old are you? _____ years old

3) What is the highest level of education you have completed?
   _____

4) Would you consider yourself religious (circle one)? Yes Somewhat No

5) Have you or anyone you know in the African American community ever gone to see a doctor, psychiatrist, psychologist, social worker, therapist, or counselor for a mental, emotional or a behavioral problem (circle one)? Yes No

6) How long have you lived in this neighborhood? _____years and/or _____months.

THANK YOU!

APPENDIX D

Table D1: Factor loadings for 40 key informants for the sources of stress from the one factor solution demonstrating that key informants are from a shared culture with respect to their perceptions about significant stressors

Variable	Factor1	Variable	Factor1
Informant 1	0.9041	Informant 21	0.9261
Informant 2	0.9293	Informant 22	0.9323
Informant 3	0.9378	Informant 23	0.9738
Informant 4	0.8793	Informant 24	0.8906
Informant 5	0.7511	Informant 25	0.8927
Informant 6	0.9922	Informant 26	0.6885
Informant 7	0.6949	Informant 27	0.8713
Informant 8	0.9023	Informant 28	0.8755
Informant 9	0.8822	Informant 29	0.8987
Informant 10	0.7958	Informant 30	0.7988
Informant 11	0.7788	Informant 31	0.8858
Informant 12	0.8485	Informant 32	0.8252
Informant 13	0.9605	Informant 33	0.8868
Informant 14	0.8807	Informant 34	0.8923
Informant 15	0.7964	Informant 35	0.8648
Informant 16	0.8981	Informant 36	0.9034
Informant 17	0.7992	Informant 37	0.7932
Informant 18	0.6946	Informant 38	0.8814
Informant 19	0 .7999	Informant 39	0.9047
Informant 20	0.9171	Informant 40	0.8687

Table D2: Factor loadings for 40 key informants for ways of dealing with stress from the one factor solution demonstrating that key informants are from a shared culture with respect to their perceptions about ways of dealing with stress.

Variable	Factor1	Variable	Factor1
Informant 1	0.8917	Informant 22	0.7546
Informant 2	0.8917	Informant 23	0.9322
Informant 3	0.8663	Informant 24	0.8187
Informant 4	0.7748	Informant 25	0.7253
Informant 5	0.6951	Informant 26	0.5229
Informant 6	0.5922	Informant 27	0.9055
Informant 7	0.8900	Informant 28	0.7048
Informant 8	0.6013	Informant 29	0.9002
Informant 9	0.8222	Informant 30	0.8097
Informant 10	0.6084	Informant 31	0.9008
Informant 11	0.7880	Informant 32	0.8029
Informant 12	0.9003	Informant 33	0.6026
Informant 13	0.9016	Informant 34	0.9015
Informant 14	0.6972	Informant 35	0.6919
Informant 15	0.9490	Informant 36	0.9131
Informant 16	0.8981	Informant 37	0.6722
Informant 17	0.7231	Informant 38	0.8359
Informant 18	0.9804	Informant 39	0.9106
Informant 19	0.5688	Informant 40	0.8061
Informant 20	0.6705		
Informant 21	0.9261		

Table D3: Factor loadings for 40 key informants for indicators of depression from the one factor solution demonstrating that key informants are from a shared culture with respect to their perceptions about depression.

Variable	Factor1	Variable	Factor1
Informant 1	0.6989	Informant 21	0.5014
Informant 2	0.7108	Informant 22	0.9218
Informant 3	0.9072	Informant 23	0.7992
Informant 4	0.8902	Informant 24	0.6514
Informant 5	0.9291	Informant 25	0.9126
Informant 6	0.8356	Informant 26	0.8755
Informant 7	0.5277	Informant 27	0.6457
Informant 8	0.8539	Informant 28	0.8149
Informant 9	0.7607	Informant 29	0.8134
Informant 10	0.8179	Informant 30	0.4732
Informant 11	0.5022	Informant 31	0.5854
Informant 12	0.6023	Informant 32	0.9030
Informant 13	0.7351	Informant 33	0.7977
Informant 14	0.4913	Informant 34	0.6816
Informant 15	0.9127	Informant 35	0.8833
Informant 16	0.6729	Informant 36	0.6802
Informant 17	0.9004	Informant 37	0.9000
Informant 18	0.8678	Informant 38	0.428 9
Informant 19	0.8971	Informant 39	0.6099
Informant 20	0.6970	Informant 40	0.8959